Learning from Deaths Report Q2 2023/24

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	29th November 2023		
Document Title:	Learning from Deaths Q2 2023/24		
Responsible Director:	Prof Alastair Hutchison	Date of Executive Approval	
Author:	Dr Julie Doherty / Prof Alastair Hutchison		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	No. However formatted in line with SW Regional guidance. Breadth of data presented is recognised as an exemplar within SW Region.		

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

3. Purpose of the Paper	To inform the Board of the learning occurring from deaths being reported,investigated and appropriate findings disseminated throughout the Trust. To alsooutline additional measures put in place to assure the Trust that unnecessary deathsare not occurring at DCH despite the elevated SHMI. Presentation of the Learning fromDeaths report at Quality Committee and Trust Board is a mandatory obligation for allTrusts.						
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve (✓)*
4. Key Issues	The latest published SHMI data (5 months in arrears) for DCH was within the 'Expected Range' for the rolling 12 months to April, May and June 2023 (1.125, 1.116, 1.110; page 7). No other local or national indicators suggest excess unexpected deaths are occurring at DCH, but SW Region acting through Dorset ICS, are seeking additional assurance from an external audit of Structured Judgment Reviews (SJRs). SJRs 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. Prof Hutchison completed an internal SJR audit in Oct 2023, of 65 deaths occurring in September 2022 and June 2023 to look for unexpected events, and this report is also tabled at HMG and Quality Committee this month. This will be independently reviewed by Dr. Sean Weaver under the auspices of SW Region & Dorset ICB.						
5. Action recommended	The Board is recommended to: 1. **DISCUSS and NOTE** the findings of the report 2. **DISCUSS** the additional scrutiny occurring 3. **APPROVE** the report and escalate to Trust Board						

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, and the overall trend in DCH's SHMI is favourable.
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.

		There is currently a high level of uncoded activity relating to resources within the clinical coding dept and a national preference from coders for remote working – negatively impacted by DCH's backlog in scanned medical records. This could impact future SHMI stats. • 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 2 2023/24 Report

Structured Judgement Review Results:
The Family Services & Surgery Division had 57 deaths in quarter 2, of which 53 that require SJR's to be completed. Within quarter 2 56 SJR's have been completed from this quarter and previous months.
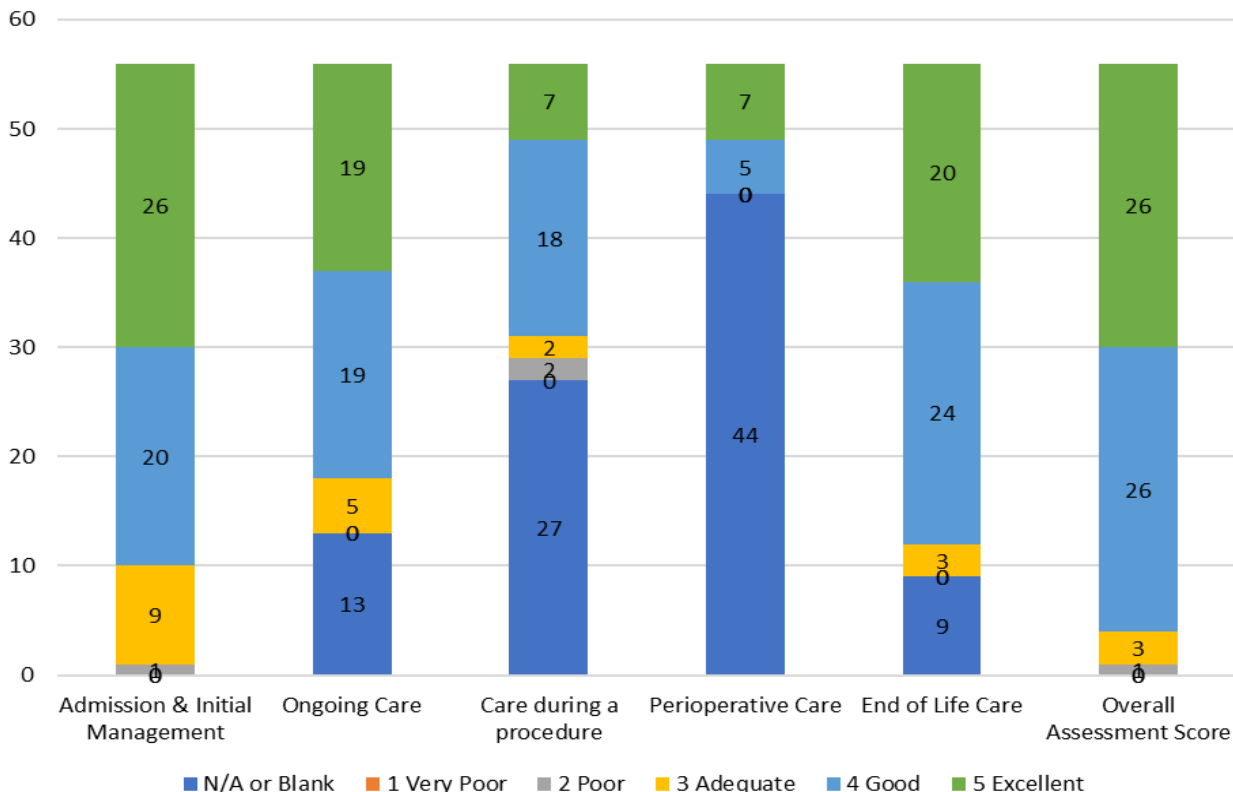
Outstanding SJR's:
The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 31/10/2023 is 15:

June	July	August
4	3	8

Feedback from SJR's Completed in Quarter 2:

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	13	27	44	9	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	2	0	0	1
3 Adequate	9	5	2	0	3	3
4 Good	20	19	18	5	24	26
5 Excellent	26	19	7	7	20	26

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	2	5	27	22

- Clear and concise reviews, plans and interventions documented, plus the two way conversations had between staff and patients family.
- Comprehensive documentation by Drs and nursing staff.
- Documentation limited about decision to operate.
- Full ERCP report - well written.
- Good entries. Clear handwriting. Thinking of doctors is clear. Clerking was complete. Nursing entries are good.
- No Consultant documentation or written evidence that they were involved in any decision making until next morning.
- Record was good but notes loose and in wrong order.
- Some omissions in initial surgical clerking but otherwise entries are comprehensive and legible.

Ongoing issue with patients' medical records being scanned to DPR before the SJR has been completed. There is a process in place 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). Quality Manager continues to monitor when the Mortuary have released the records to obtain them before they go to the scanning team to try and mitigate this.

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	0	9	47

Action Required:
Following completion of the 56 SJR's, 10 were highlighted as requiring actions.

Further learning via:
- 6 were for formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.

Other actions:
- Refer to ward manager for further investigation – completed - outcome fed back to reviewer.
- M and M meeting – scheduled for October meeting.
- Email out to all Consultants re need to document review at weekend – completed.
- Feedback to CT3 excellent care – completed.

Learning from Division:

SJRs are now routinely being completed by both Medical and Nursing staff to provide an MDT approach and ensure all aspects of a case are reviewed. Once the new Surgical ANP's have become more embedded within their positions they will undertake training to enable them to also complete SJR's along with the Critical Care Outreach Team and Theatres & Anaesthetics Matron.

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

1.2 Division of Urgent & Integrated Care – Quarter 2 Report 2023/24

Structured Judgement Reviews
In quarter 2 there were 183 deaths, 47 SJR's were requested from these deaths and 33 SJR's were completed during this period (completed SJR's not necessarily from this quarter). There were 4 more completed SJR's, however these are yet to be closed as have outstanding actions and so these will show on the next report (Datix report pulls from date incident closed and not date SJR completed)

|	Q2			Q3			Q4			Q1			Q2			Total YTD
	Jul	Aug	Sep	Oct	Nov	Dec	Jan-23	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Deaths	61	46	55	57	62	73	71	61	69	61	60	57	65	58	60	361
Deaths requiring SJR'S from Month	15	9	5	10	10	8	7	9	11	10	10	14	15	14	18	81
*Completed SJR'S	15	9	17	3	10	5	1	8	14	5	12	16	2	14	17	66

* Completed SJR'S not necessarily from that month's deaths

SJR data as of 23/10/2023 (not including outstanding nosocomial reviews): **45**

SJR's with an allocated clinician = **1**
Total outstanding SJR's (not including allocated) = **44**
Outstanding SJR's >2 months = **20**
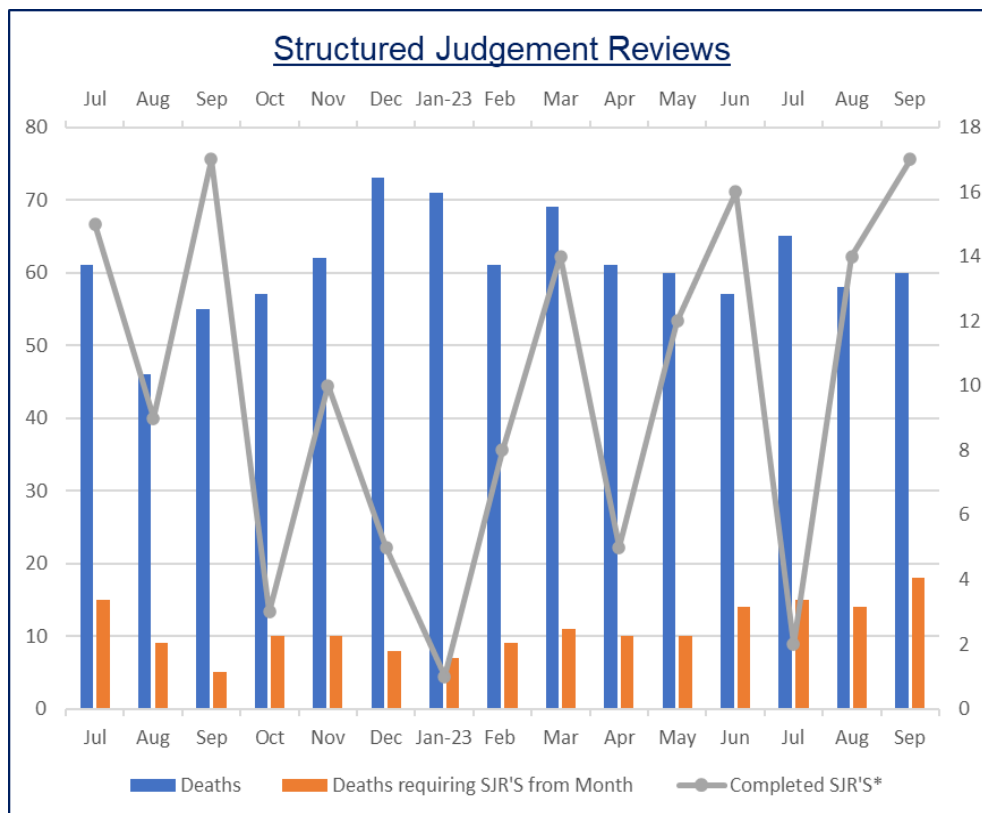
Nosocomial SJR Requests
18 Nosocomial deaths (17/10/2021 – 30/04/2022), 8 reviewed by James Metcalf, 10 to review with Emma Hoyle **– Meeting in July cancelled – Still to be re-scheduled.**

Quarter 2 Results These results include 19 completed SJR's by the CMO as part of a random sample review during July/Aug/Sept

Phase score from 52 completed SJR's in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	EoL Care	Overall Assessment Score
N/A or Blank	1	*16	34	50	13	3
1 Very Poor	--	--	--	--	--	--
2 Poor	--	--	--	**2	--	--
3 Adequate	2	2	--	--	2	--
4 Good	45	32	17	--	36	47
5 Excellent	4	2	1	--	1	2

*2/16 not scored for 'Ongoing Care' others documented at N/A – Not scored fed back to clinicians who completed SJR's – AH/TG 23/10/23
**Score 2 (poor) for 'Perioperative Care' – require 2nd SJR's – ongoing
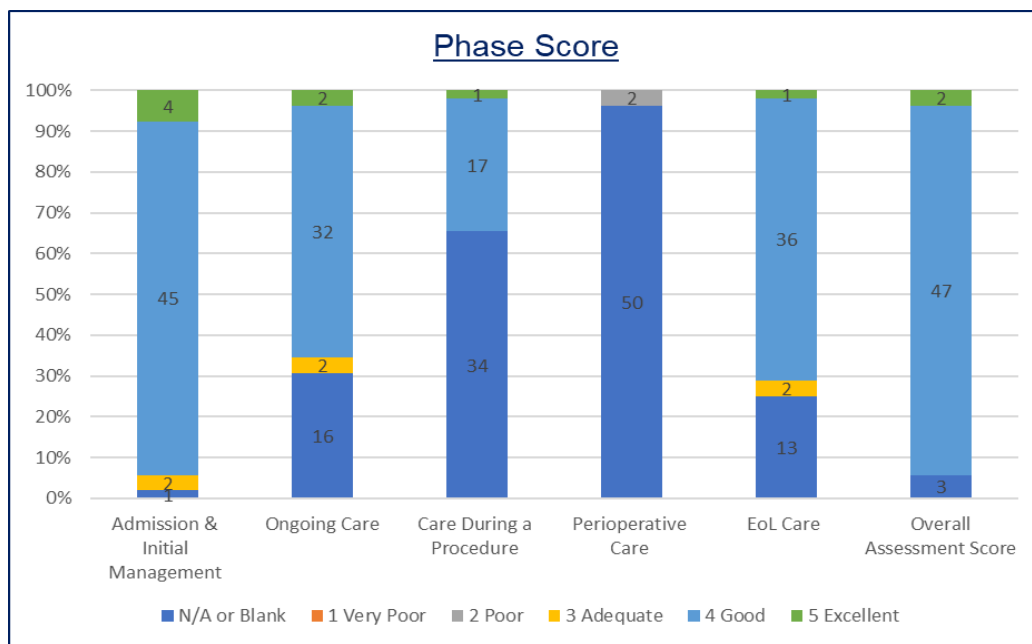
Overall quality of patient record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
*1	--	--	5	40	6

* Part of random sample review

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 likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	*1	3	48

* Part of random sample review by AH - Scored 4 because of hospital acquired covid leading to pneumonitis, and likely contributed to death – Documented no further actions required – Report will be shared at Elderly Care M+M Meeting.

SJR Key themes from Areas of Good Practice:
- Good involvement of patient and/or family
- Good documentation

SJR Key theme of Areas for Improvement:
Not enough data input in SJR's to collate a key theme. Only 3 entries in total highlighted:

- Not recognised appropriate start of EoL

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

Divisional Morbidity and Mortality reviews

Outcomes from M&M meetings are now being provided to the monthly Hospital Mortality Group and can be obtained on request, but since they contain patient-specific details are not included in this report.

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 the three rolling 12-months to April, May and June 2023 were within the expected range. We are aware that our data continues to be adversely influenced by short staffing/difficulty recruiting to two posts in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record.

Victoria Stevens (Clinical Coding Dept. Manager) reports that the Clinical Coding Department cleared the coding backlog prior to the final deadline for annual HES data submission, but the IT company responsible for uploading the submission failed to meet the deadline for data from DCH and 26 other Trusts. This is likely to continue to adversely influence the accuracy of DCH's SHMI data, until it is incorporated into the publication from this month onwards. DCH has successfully appointed two apprentice coders who will be trained over the next 24 months; however, one leaver from the coding team at DCH means that the dept remains under strain due to vacancies.

The coder is leaving DCH to join a larger team with greater remote working opportunity. **Nationally there is a preference from coders to work remotely. The fact that there is a significant amount of work from coding from paper records needing to be actioned on site is impacting recruitment & retention at DCH.**

The latest published SHMI (rolling year to June 2023) is shown below:
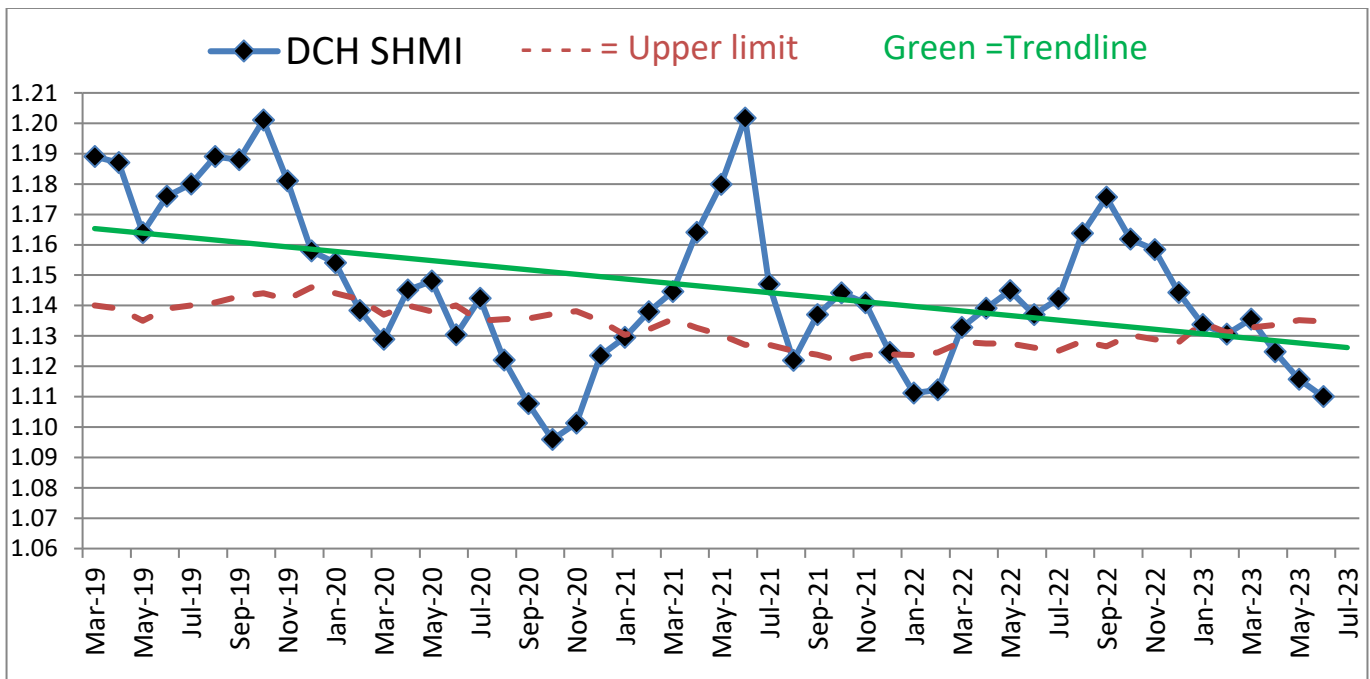
SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions). From 2019 onwards there has been a steady trend of improvement in DCH's SHMI (bar one peak in June 2021) associated with focus on SJRs, M&M meetings and a full Medical Examiner service, plus investment in the coding department which will result in more accurate coding returns to NHSE (formerly NHS Digital).

2.2 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 show a tendency to decrease, but with a stabilisation in the latest quarter. All data points represent 12 months of data.
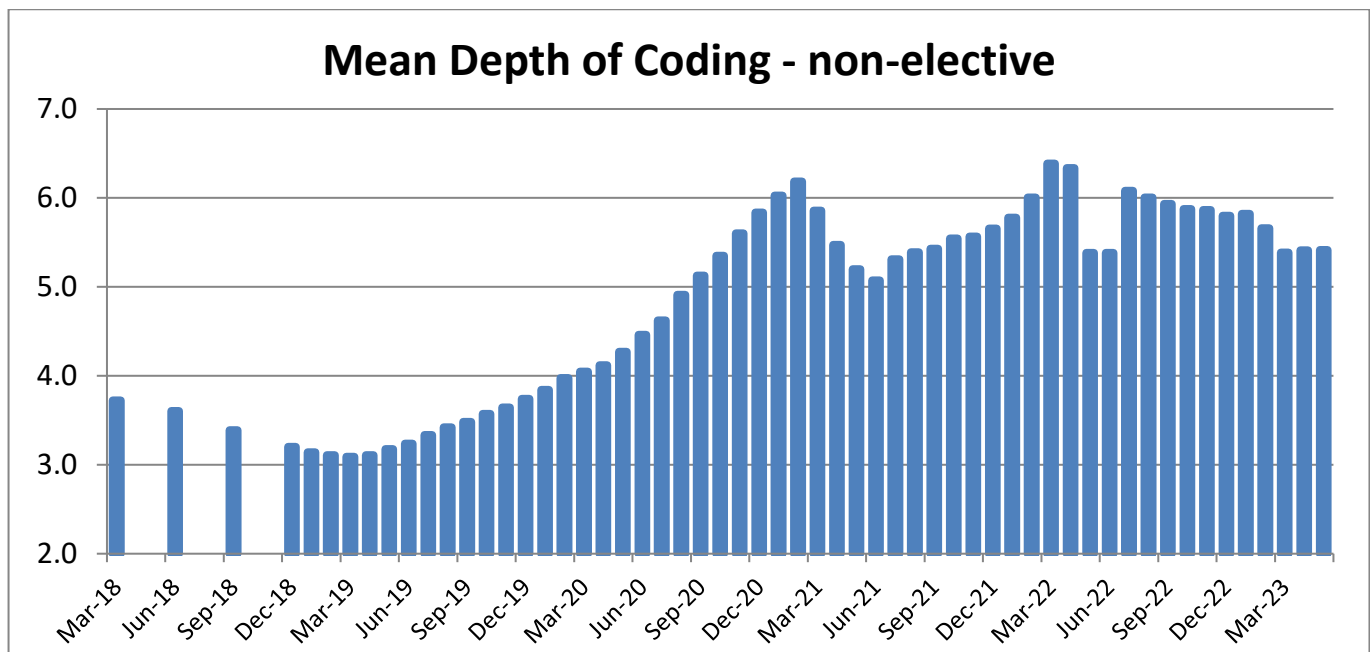
2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths over the past 4+ years (rolling years from March 18 to March 23), the numbers of which are directly influenced by the number of in-patients, particularly during and immediately after the covid-19 pandemic. Whilst both observed and expected deaths tended to decrease over the 7 months to October 22 (as the total number of in-patients has tended to decrease), the expected deaths have recently increased back to their average of around 950 per 12 months.
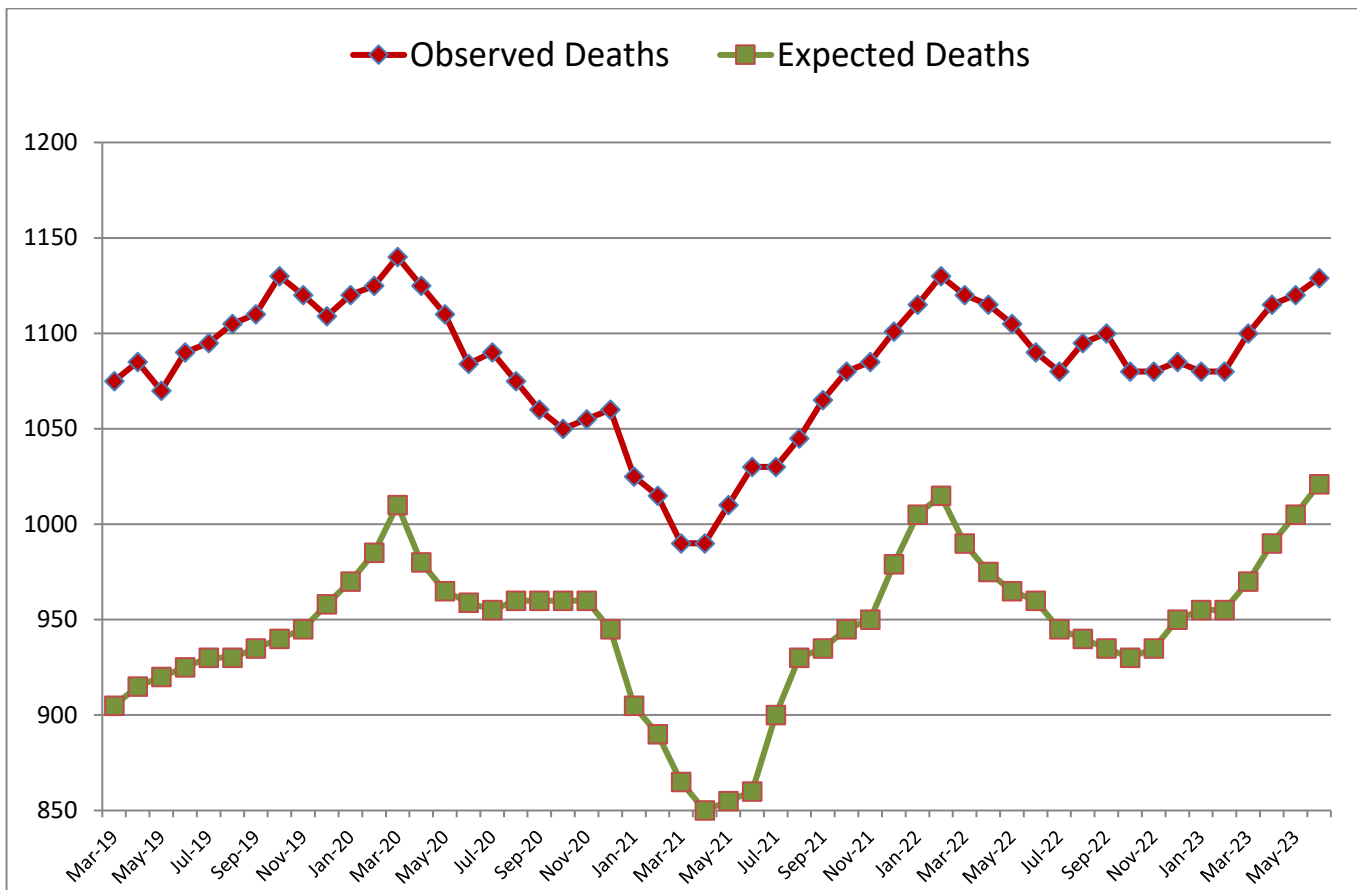
3.0   OTHER NATIONAL AUDITS/INDICATORS OF CARE

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.

For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment 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 iterations of a "National Maternity Dashboard". This data is also contained within the monthly Quality report.
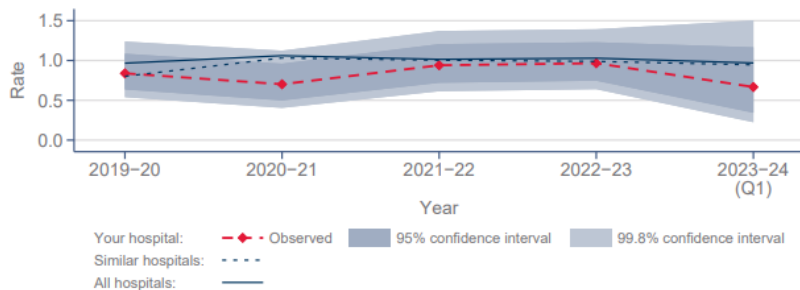
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from April 2023 to June 2023 (quarter 1) was published on 18/10/2023. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven. A total of 12 cardiac arrest calls were recorded for this 3-month period.

The graph below (left) 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 the table summarises the past 5 years.

Rate of cardiac arrests per 1000 hospital admissions
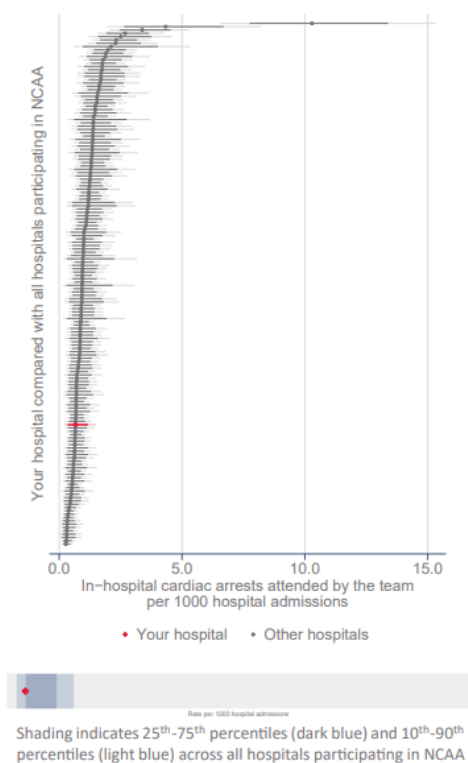
	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	17988	12	0.67	(0.34, 1.17)	(0.22, 1.50)
Quarter 2					
Quarter 3					
Quarter 4					
Year to date	17988	12	0.67	(0.34, 1.17)	(0.22, 1.50)

Your hospital: — ◆ · Observed   ▮ 95% confidence interval   ▮ 99.8% confidence interval
Similar hospitals: · · · ·
All hospitals: ——

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

• Your hospital   • Other hospitals

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

The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

a) Time to '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 Quarter 1 (published 18/10/2023).

Risk-adjusted outcomes: Dashboard
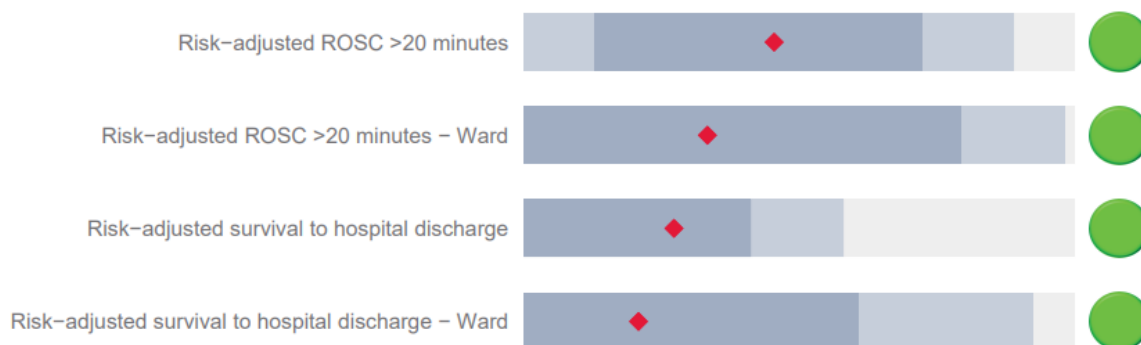
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.
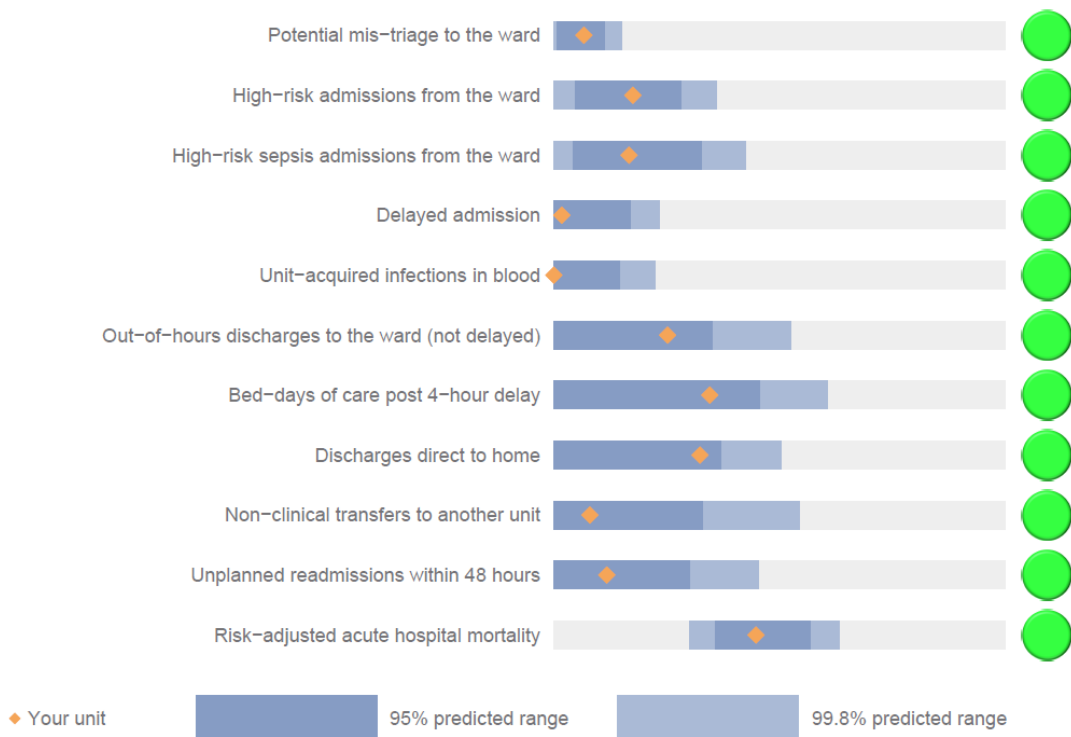
3.3 ICNARC Intensive Care survival data for financial year 2023/24; published 07/11/2023; n = 313 patients.

There are no amber or red indicators in this quarter's chart where previously there were 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 a welcome improvement.

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2023 to 30 September 2023

Quality indicator dashboard

- Potential mis-triage to the ward
- High-risk admissions from the ward
- High-risk sepsis admissions from the ward
- Delayed admission
- Unit-acquired infections in blood
- Out-of-hours discharges to the ward (not delayed)
- Bed-days of care post 4-hour delay
- Discharges direct to home
- Non-clinical transfers to another unit
- Unplanned readmissions within 48 hours
- Risk-adjusted acute hospital mortality

◆ Your unit   95% predicted range   99.8% predicted range
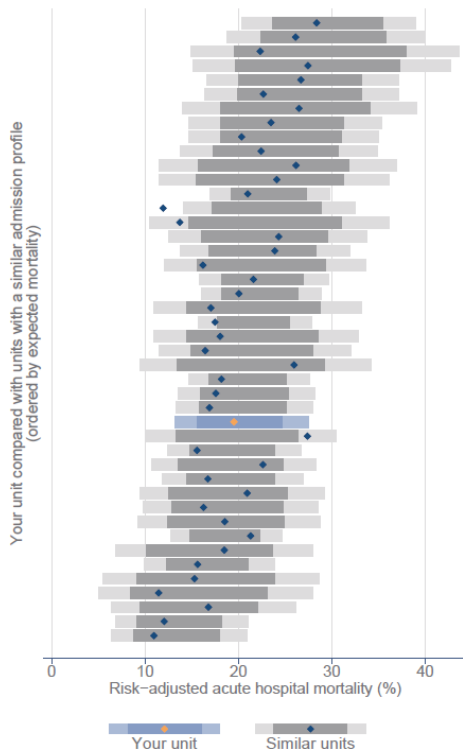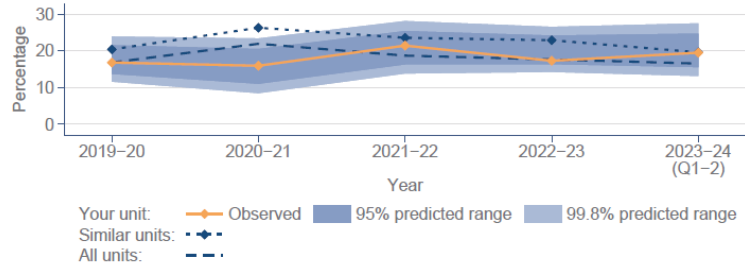
Date of report: 07/11/2023   6   ©ICNARC 2023

The charts below show the "risk-adjusted acute hospital mortality" following admission to the DCH Critical Care Unit in Q1 – Q4 2022/23. They compare observed and expected death rates in a similar fashion to SHMI, with expected deaths of 124 but actual deaths of only 106.

Risk-adjusted acute hospital mortality

	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	148	147 (99.3)	🟢	29 (19.7)	22.0	(15.1, 28.5)	(11.7, 32.7)	🟢
Quarter 2	153	150 (98.0)	🟢	29 (19.3)	18.5	(12.1, 24.6)	(9.0, 28.5)	🟢
Quarter 3								
Quarter 4								
Year to date	301	297 (98.7)	🟢	58 (19.5)	20.2	(15.6, 24.7)	(13.2, 27.5)	🟢

Your unit: Observed   95% predicted range   99.8% predicted range
Similar units:
All units:

Definition
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calculate an $ICNARC_{H-2023}$ model risk prediction and complete status at discharge from acute hospital
- Observed percentage: The number and percentage of complete eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths, calculated as the mean predicted risk of death from the $ICNARC_{H-2023}$ model, among complete 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
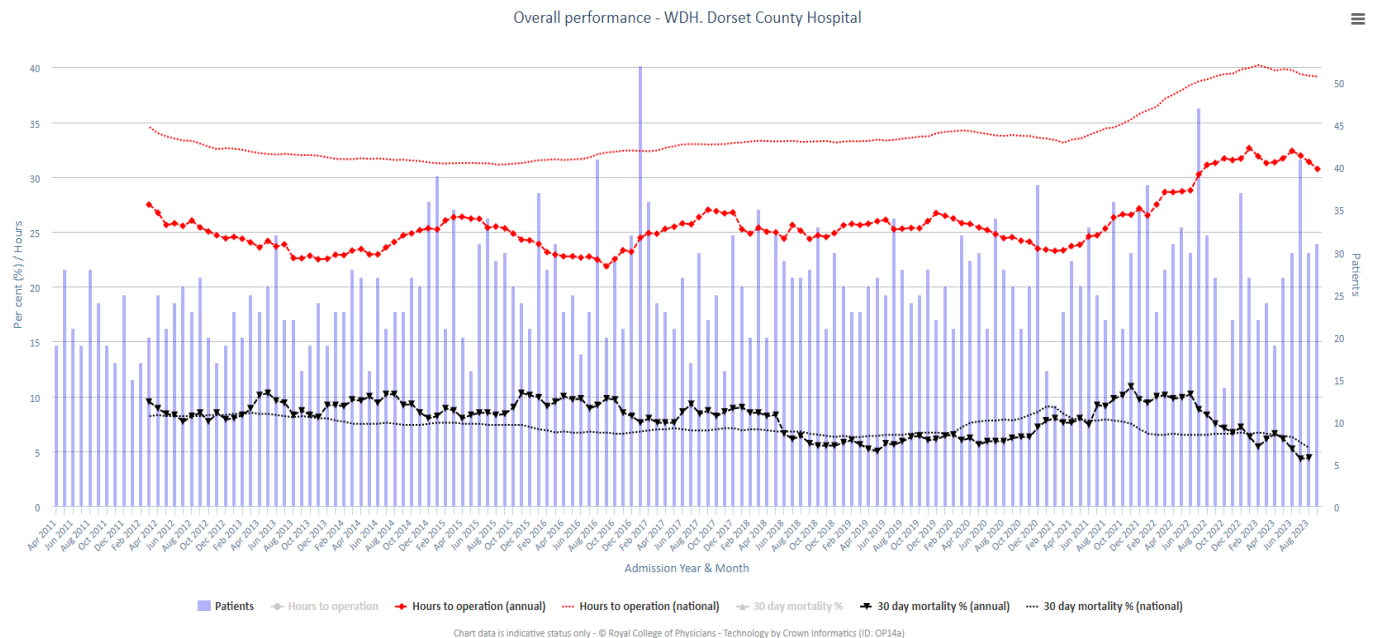
Date of report: 07/11/2023   20   ©ICNARC 2023

These results are well within the expected range.

3.5 National Hip Fracture database to August 2023

30 day mortality remains at or below the national average for 8 consecutive months.

Overall performance - WDH. Dorset County Hospital

Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: OP14a)

'Hours to operation' remains significantly better than the national average (30.7 vs 39.2 hours) and, after a post-covid rise from around 23 hours, is tending to decrease again.

3.6 National Emergency Laparotomy Audit

Patients admitted to hospital because of an acute abdominal problem will usually undergo an urgent abdominal CT scan in order to arrive at a diagnosis. They may then need a general anaesthetic and an 'emergency laparotomy' (open abdominal surgical exploration) to resolve the underlying problem. These are high risk procedures since time to optimise the patient's condition may not be available if deterioration is occurring.

A Exponentially Weighted Moving Average chart can be used to display near real-time in-hospital mortality within a single hospital . The chart below displays the expected range of mortality given the hospitals casemix, and the hospital's actual mortality. EWMAs can be used as a warning system for early detection of concerning changes in mortality rates.   The light blue line is the 'expected mortality' percentage, the dotted line is the national average, the black line is the 'observed (actual DCH) mortality percentage, and the grey area denotes the upper and lower control limits.

The mortality percentage for DCH is approximately one third of the expected mortality and on occasions is below the lower control limit suggesting that DCH's results are 'statistically significantly' better than expected for this 12 month period.
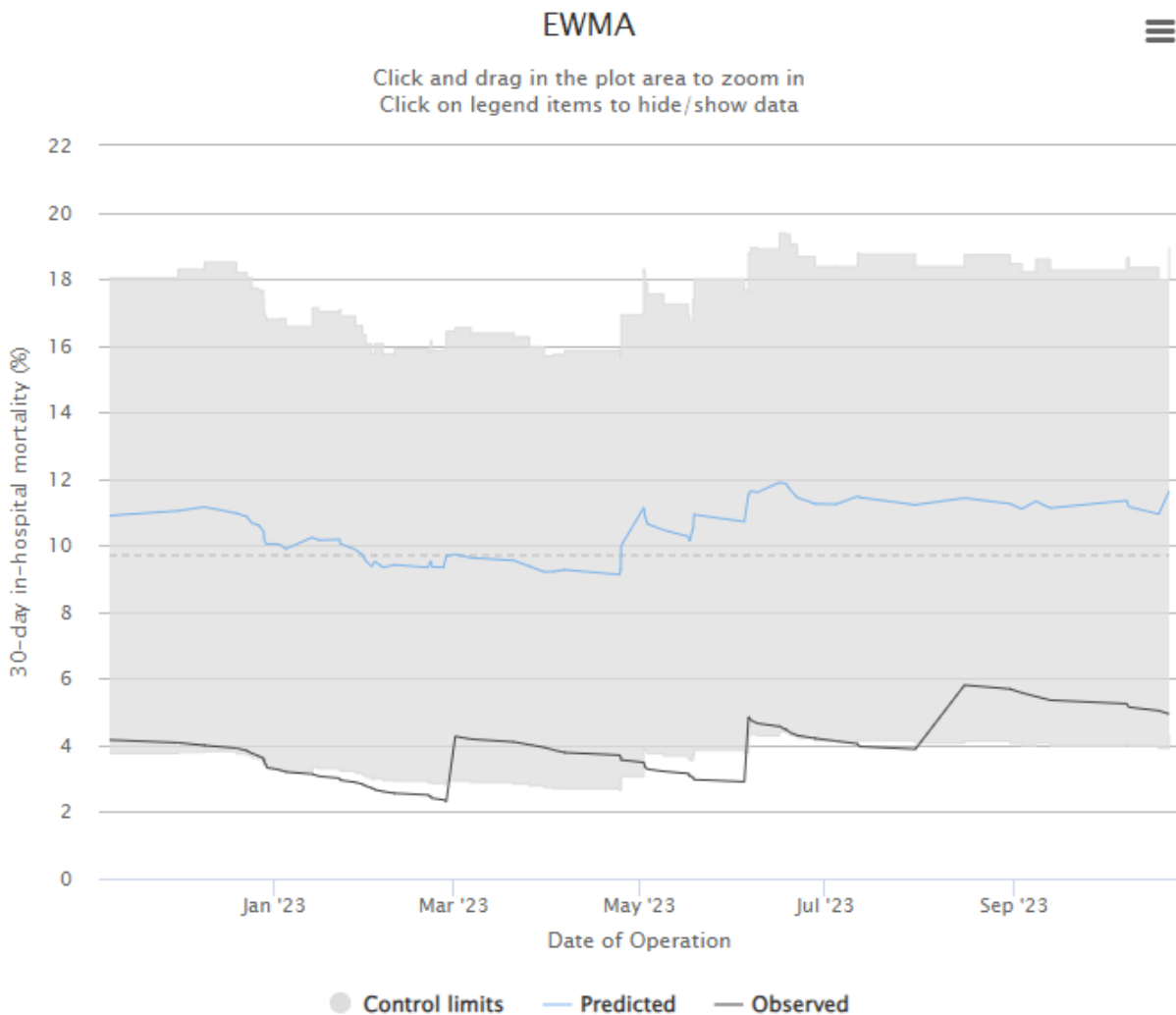
3.7 Getting it Right First Time; reviews in Qtr 2

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. A GIRFT Gateway Review for Gynaecology was conducted on the 26.07.23.

3.8 Trauma Audit and Research Network

DCH is a designated Major 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. The TARN website remains unavailable (following a cybersecurity issue).

3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better

Diagnoses | Readmission (30 days) | May 2022 - Apr 2023 | ALL (acute)
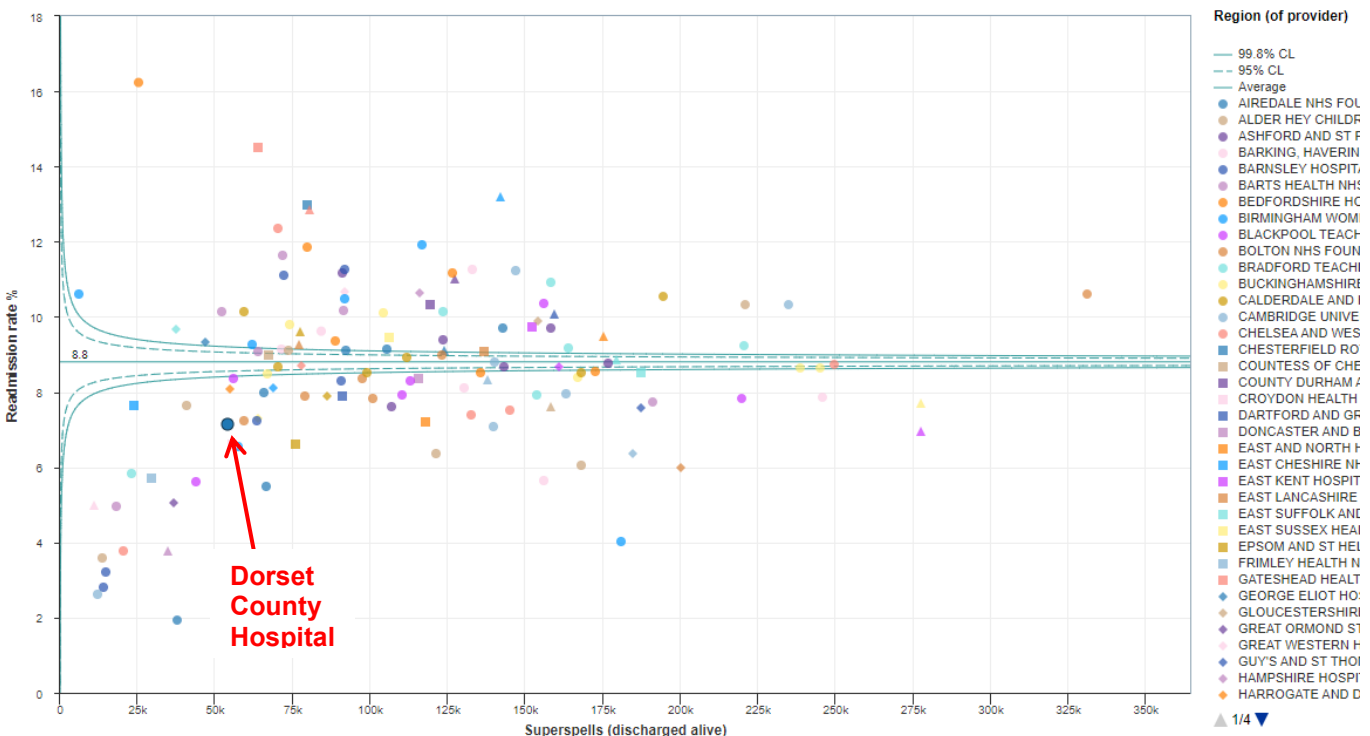
A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the average of other acute Trusts.

3.10 National Child Mortality Database

The National Child Mortality Database (NCMD) was launched on 1 April 2019 and collates data collected by Child Death Overview Panels (CDOPs) in England from reviews of all children who die at any time after birth and before their 18th birthday.

NCMD have released data for 2023, which covers child deaths notified and reviewed up until 31 March 2023. This year's data includes 3,743 child deaths in England notified to NCMD between April 2022 and March 2023, an estimated rate of 31.8 deaths per 100,000 children.

The number of deaths increased by 8% on the previous year and was the highest number of deaths in a year since NCMD started data collection in 2019.

The data gives broad insights into when and where these deaths occurred; the characteristics of the children who died, including sex and age group; and where modifiable factors were identified. It also sets these statistics against those seen in previous years. The data will be analysed in greater detail, and with more specific focus, in a series of thematic reports, which aim to pull out key findings and recommendations.

[Child death data release 2023 | National Child Mortality Database (ncmd.info)](#)

Ethnicity and social deprivation are significantly associated with poorer outcomes / higher death rates.

The **child death rate** in each region of England ranged from 24.2 to 41.1 per 100,000 population of 0-17 year olds (Figure 2), an increase on the previous year for most regions. The South West child death rate for 2023 was 24.2 per 100,000 compared to 22.7 per 100,000 in 2022.

For children aged between 1 and 17 years, the highest death rate continued to be for children aged between 15-17 years (21.3 per 100,000 population), followed by 1-4 year olds (17.6 per 100,000 population).

The **infant death rate** was 3.8 per 1,000 live births, an increase from 3.6 in the previous year nationally. South West regional rate 2.9 per 1000 live births (2.7 in 2022). However, the estimated death rate for infants born at 24 weeks or over was 2.7 deaths per 1,000 live births of the same gestational age (national data), the same rate as the previous year.

Neonatal deaths (deaths of babies under 28 days of age): The estimated **neonatal death rate** was 2.7 per 1,000 live births, an increase from 2.4 in the previous year. However, the estimated neonatal death rate for babies born at 24 weeks or over was 1.6 deaths per 1,000 live births of the same gestational age, a decrease from 1.7 in the previous year. The neonatal mortality rate ambition, derived from ONS data, is 1.0 deaths per 1,000 live births of babies born at 24 weeks or over, by 2025.

See also 'Safer Maternity Care' report 2021
[[Insert title of report] (england.nhs.uk)](#)

And MBRRACE data (latest report 2021) [MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)](#)

CDOP data: 3,271 child deaths were reviewed by CDOPs in England between 1 April 2022 and 31 March 2023 (some of these deaths may have occurred in earlier years), a 19% increase on the previous year and the highest number since 2019.

The proportion of reviews that identified modifiable factors continued to rise with 39% of deaths reviewed in the year ending 31 March 2023 identifying modifiable factors. The proportion of reviews with modifiable factors varied per region from 27% to 52%.

Deaths categorised as *Deliberately inflicted injury, abuse or neglect* had the highest proportion of reviews with modifiable factors (81%), followed by *Sudden unexpected and unexplained death* (76%)*, Trauma or other external factors* (71%) and *Suicide or deliberate self-inflicted harm* (50%). South West data: 266 child death reviews completed in 2023 of which 39% were assessed as having modifiable factors.

Locally there has been lots of learning around optimisation of care for preterm babies (PeriPrem Bundle at [https://www.swneonatalnetwork.co.uk/professionals-area/neonatal-guidelines-and-publications/south-west-work-programmes/periprem/](#)) – at perinatal M&M meetings, SCBU study days with SIM practice and CDOP learning events.

There have also been local learning events from Child Safeguarding Practice Reviews (including learning in extrafamilial abuse and child exploitation).

3.11 National Perinatal Mortality Review tool

Case review relating to antepartum stillbirth at 30 weeks gestation in a high risk pregnancy.

Grading outcome:
The review group identified care issues which they considered *may have made a difference* to the outcome for the baby.
Learning identified:
- Updated guidance on indications for serial growth scans on GROW.
- Improved communication regarding actions arising from specialist reviews
- Improved documentation on BadgerNet for action plans

Learning from previous PMRT:
- Improved process for sending placental histology
- Excellent palliative care planning and communication

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

The following themes have been identified from SJRs / discussions at HMG and are being translated into quality improvement projects:

a) A Treatment Escalation Plan (TEP) / DNACPR Task group has been set up to improve pathways of care. The aim is to support staff to undertake conversations at an early stage in care and better recognize those people for whom supportive care is more appropriate than treatment escalation, to facilitate discussions with patients / relatives as appropriate to hear their view / wishes & thereby improve care for patients. The group have met twice so far; an updated TEP policy is in progress and training resources being identified / developed with learning from the region and nationally.

b) With an elevated SHMI and in the absence of any obvious flags from SJRs, an audit of 65 consecutive deaths has been undertaken to re-examine the accuracy and quality of the SJR scrutiny, in association with the Dorset ICS Learning from Deaths committee. The audit report is presented separately. Arising from this will be a QIP for palliative care – with the aim of improving access to hospice / community care to support the wishes of people provided with EoL care plans.

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 to and reviewed by the Divisional Clinical Governance meetings.

Examples of learning from the paediatric, anaesthetic and ED teams which meet regularly for Paediatric M&M (led by Dr C Hollingsworth):
- Many examples of high quality care and interdepartmental collaboration
- Gaps in service provision identified and discussions between DCH Paediatrics & UHS / SORT to facilitate care (e.g children requiring endoscopy but do not meet criteria for surgical specialty services- case by case discussions and access to surgical specialty facilitated; 16-18yr oncology pathways updated & clarified)
- Time critical transfer arrangements and discussions between SWAST / HEMS / SORT to facilitate these.
- Improved written communication regarding DCH consultant allocated to facilitate quality improvement of discharge summaries and follow up care for children returning to DCH from tertiary centre.
- Revision of triage pathways & importance of quality of referrals with access to further information where necessary.
- Guideline updates (including update of developmental delay screening investigations on ICE; guidance on shunt tap if blocked VP shunt)
- Individualised care plans documented on DPR for emergency presentations.
- Planned review of process for timely updating of long term open access forms.

6.0   LEARNING FROM CORONER'S INQUESTS Q2

DCH has been notified of 16 new Coroner's inquests being opened in the period 01 July 2023 – 30 September 2023.

10 inquests were held during Quarter 2. 7 inquests were heard as Documentary hearings, not requiring DCH attendance. 2 required the clinician to attend Court in person. 1 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams. The Risk Team no longer have a dedicated Virtual Court Room, due to office re-configuration. 3 pre-Inquest Review hearings were held.

We currently have 44 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No Regulation 28 (Preventive Future Death Notices) have been given during this quarter.

We continue to work with the Coroner's office, and will continue to support staff before, during and after 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.

No specific new learning identified: Reminders of good practice in documenting clinical discussions between clinicians in different organisations; communication & printing AGYLE records where appropriate for handover care to community hospitals.

7.0   LEARNING FROM CLAIMS Q2

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 process is currently under review.

Claims pattern Quarter 2 FY 23/24.

New potential claims	12
Disclosed patient records	28 (13 claims, 15 disclosures to the coroner)
Formal claims	3 clinical negligence, 3 employee claim
Settled claims	7 clinical negligence, 0 employee claims
Closed - no damages	8 clinical negligence, 0 employee claims

8.0   SUMMARY

SHMI improved as predicted in the rolling years to April, May and June 2023, and has been within the 'as expected' range for 5 of the last 6 months with an on-going trend to improvement.

All mortality data requires on-going scrutiny and an audit of approximately 65 deaths has been completed and is tabled for the same Quality Committee meeting as this paper. Additional external oversight has been arranged through the ICS and a link has been established with Dr Sean Weaver, mortality lead at UHD.

The coding department continues to attempt to recruit to establishment and has recruited two apprentice coders who will complete their training over the coming two years.

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, including the National Hip Fracture Audit. 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, Medical Examiners and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.