Learning from Deaths Report Q1 2024/25

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:	09 October 2024		
Document Title:	Learning from Deaths Q1 2024/25		
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	11 Sept 2024	
Quality Committee	17 Oct 2024	Escalated to Board

3. Purpose of the Paper	To inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite a previously elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts.							
	Note (✓)		*Discuss (✓)*		*Recommend*		*Approve (✓)*	
4. Key Issues	The latest published SHMI data (5 months in arrears) for DCH was 1.0995 This is within the expected range. SHMI data is showing a decreasing trend at DCHFT. We do have concerns that our SHMI may become adversely affected by the lack of resources within the clinical coding dept. Uncoded activity affects our expected mortality.							
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 publication of the report							

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 reduction in SHMI is 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 essential to the Trust's ability to assess quality of care. The Dept remains short-staffed and mitigation measures are in place including coding from EDS/ DPR. There is a risk around agency coders and compliance with NHS Framework. • 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 1 2024/25 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 57 deaths in quarter 1, of which 56 that require SJR's to be completed. Within quarter 1 62 SJR's have been completed from this quarter and previous months.

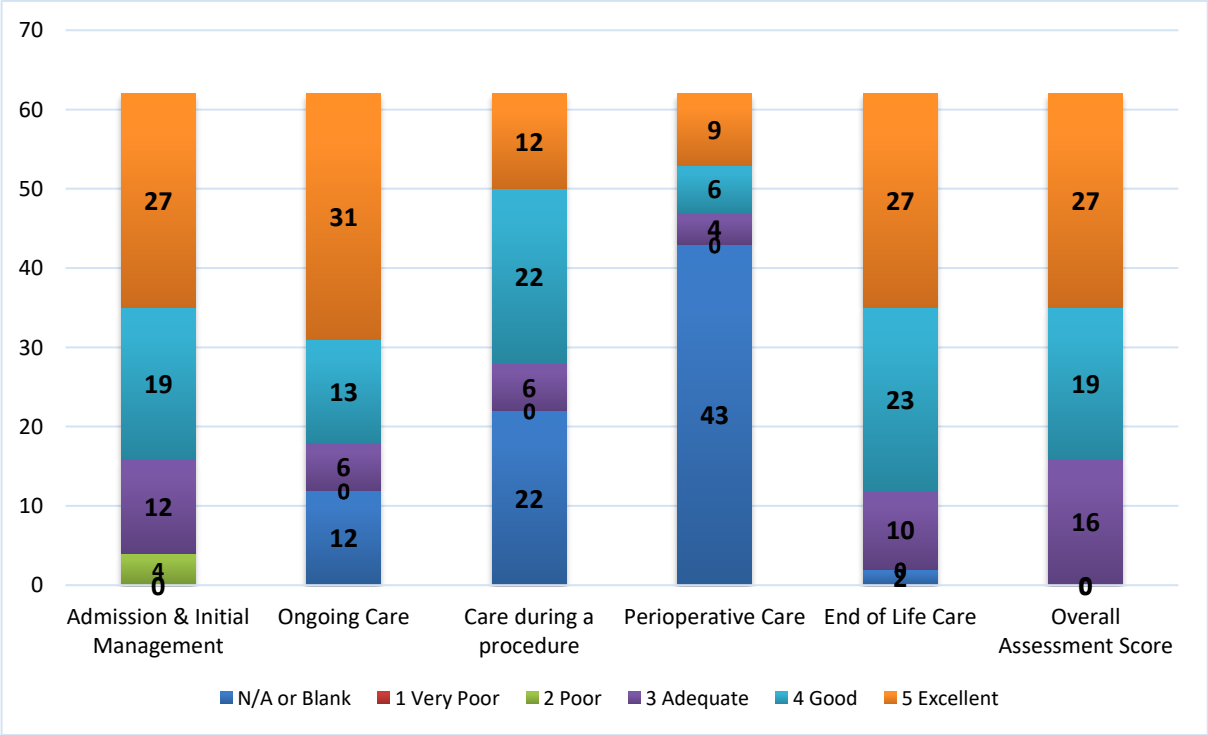
Outstanding SJR's:

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 01/08/2024 is 18:

January	February	March	April	May
3	1	1	3	10

Feedback from SJR's Completed in Quarter 1:

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	12	22	43	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	4	0	0	0	0	0
3 Adequate	12	6	6	4	10	16
4 Good	19	13	22	6	23	19
5 Excellent	27	31	12	9	27	27



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	7	26	28

- Initial phase and ED documentation Comprehensive. ITU plan well-documented and excellent documentation of ongoing developments.
- Medical registrar documentation was excellent.
- Urology SHO records well documented and clear. Medical team records incomplete and poorly documented. ENT adequate.
- The patient record documentation is lacking in initial phase and especially vitals are not documented in detail, the surgical plan was not inclusive of clear DNAR and TEP plan. Renal registrar and ITU reviews were detailed and comprehensive.
- Loose notes, wrong order.
- Initially very good. Lacking findings of relevant and essential investigations.

The Quality Manager continues to monitor when the Mortuary/Clinical Coding have released the records to obtain them before they go to the scanning team to try and mitigate being scanned to DPR before the SJR has been completed.

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	8	54

Action Required:

Following completion of the 62 SJR's, 11 were highlighted as requiring actions.

Further learning via:

- 3 were for formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.
- 2 were for newsletter inclusion and for formal documented feedback to Department or clinical team.

Other actions:

- 3 for review and discussion at Specialty M&M/Clinical Governance meetings.
- 1 was referred to HMG for discussion.
- 1 requested second SJR from specific specialty.
- 1 was referred for 2nd opinion on diabetic management from physician.

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.

Emerging Themes:

1. Documentation procedures improving
2. DNACPR – lack of continuity decision – in hospital on discharge as well as community into ED.
3. Inappropriate and prolonged resuscitation seems to be increasing

1.2 Division of Urgent & Integrated Care – Quarter 4 Report 2023/24

In quarter 1 there were 145 deaths, 32 SJR's were requested from these deaths, and 25 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q1			Q2			Q3			Q4			Q1		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun
Deaths	61	60	57	65	58	60	49	41	63	65	59	69	48	52	45
Deaths requiring SJR'S from Month	10	10	14	15	14	18	11	14	13	15	16	12	9	8	15
*Completed SJR'S	5	12	16	2	14	17	20	12	3	7	11	2	6	10	9

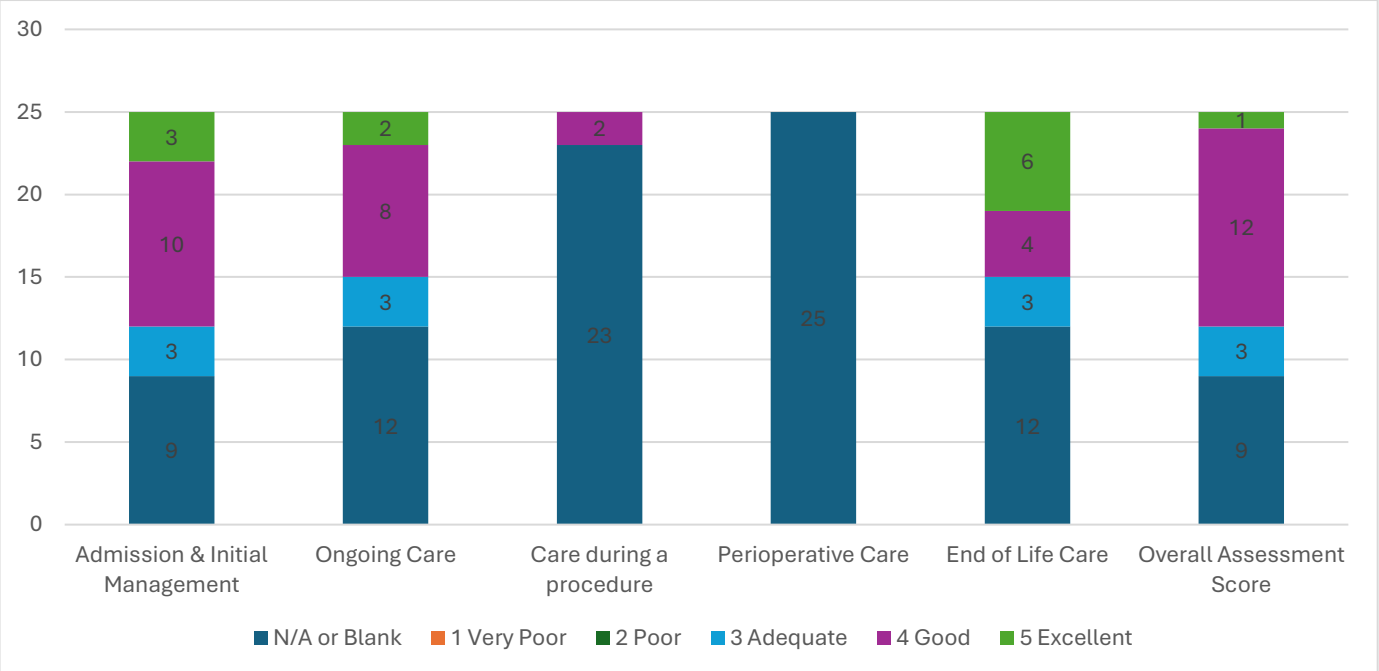
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 01/08/2024 is 82 including outstanding nosocomial reviews:

Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1	1	1	0	3	5	0	2	7	2

Phase score from 25 completed SJR's in quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	9	12	23	25	12	9
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	3	3	0	0	3	3
4 Good	10	8	2	0	4	12
5 Excellent	3	2	0	0	6	1



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
9	0	0	5	8	3

- Notes difficult to locate and would prefer for them to be on DPR
- Filing issues made notes difficult to follow. 2 date errors spotted but otherwise comprehensive.
- Good thorough documentation but incorrectly filed so difficult to follow. Illegible handwriting throughout which made it difficult to decipher
- Notes uploaded to DPR backwards
- Initial clerking record poor, occasions where time not always documented when review took place or entry in to the notes

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	2	14

Action Required:

Following completion of the 25 SJR's, 3 required further actions:

- 1 was highlighted as requiring review by the responsible team where sepsis was implicated in cause of death but sepsis pathway had not been instigated as the haemodynamic changes were attributed to beta-blocker therapy.
- 1 referred to Hospital Mortality Group (HMG) - as would be good to share with federated partners and review care.
- 1 referred to the general surgical team as reviewer contests Covid as being the cause of death.

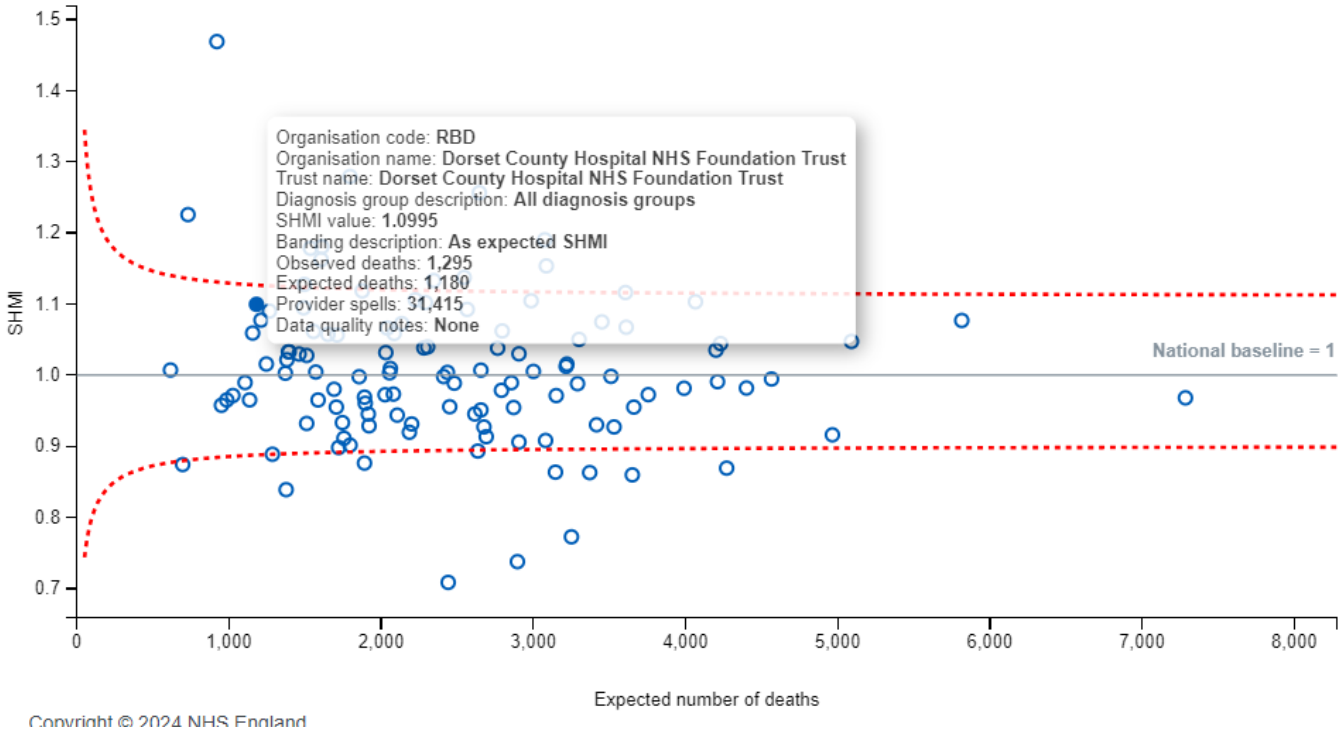
For further LfD and QIP see section 4.

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

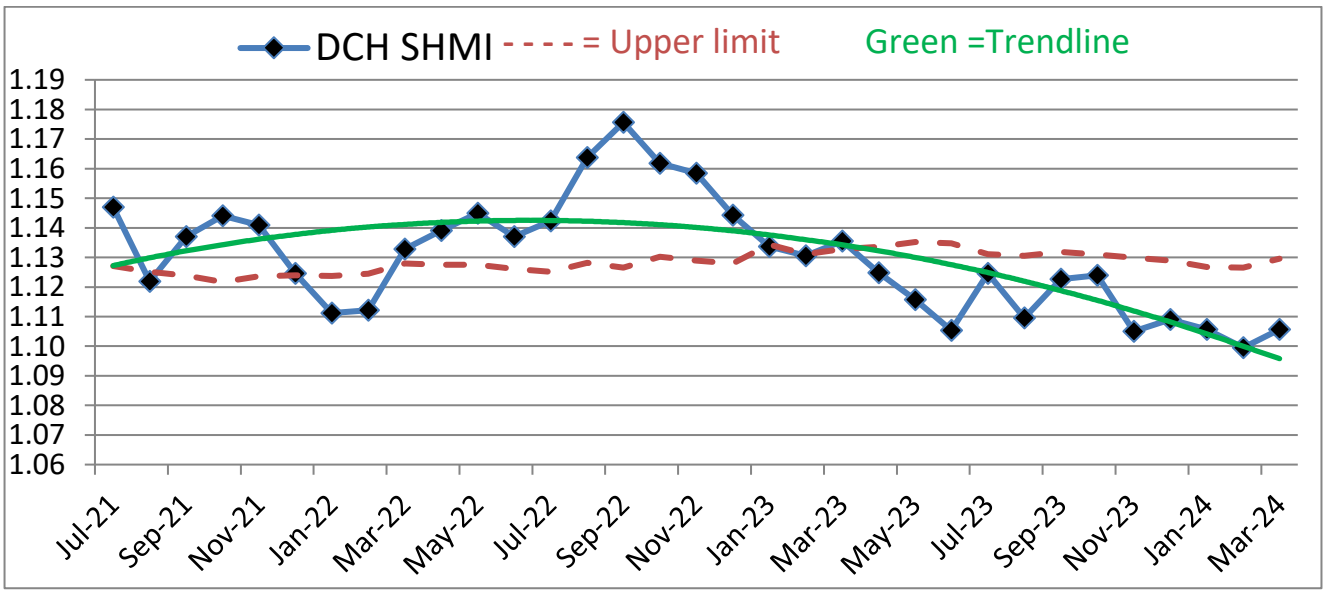
2.1 Summary Hospital-level Mortality Indicator (SHMI)

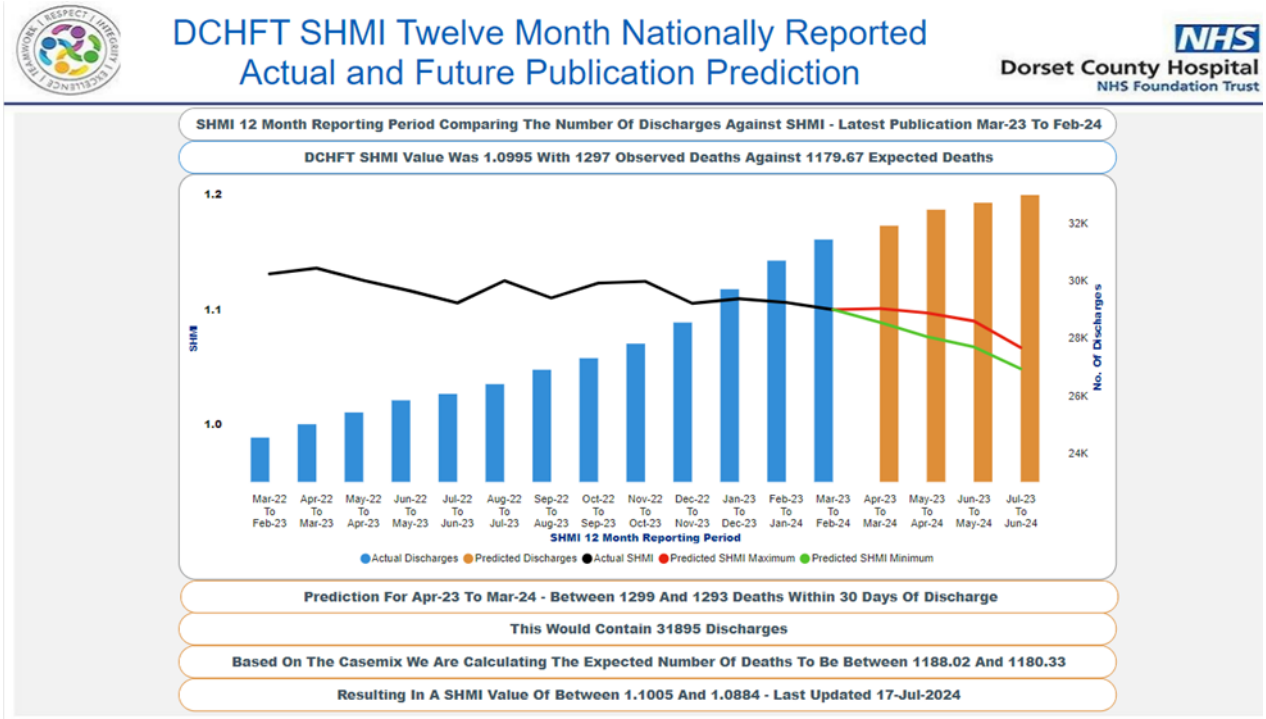
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

The latest SHMI publication from NHS England is for the period March 2023 – Feb 2024. **The Trust's figure is 1.09 which is within the expected range** using NHS England's control limits.



We are aware that our data is influenced by staffing levels in the Coding Department (though mitigations in place), and a possible under-reporting of 'sepsis' in the medical record.
Septicaemia is a recurring alert and further exploration of this is being undertaken (with support from the Deteriorating Patient Group).



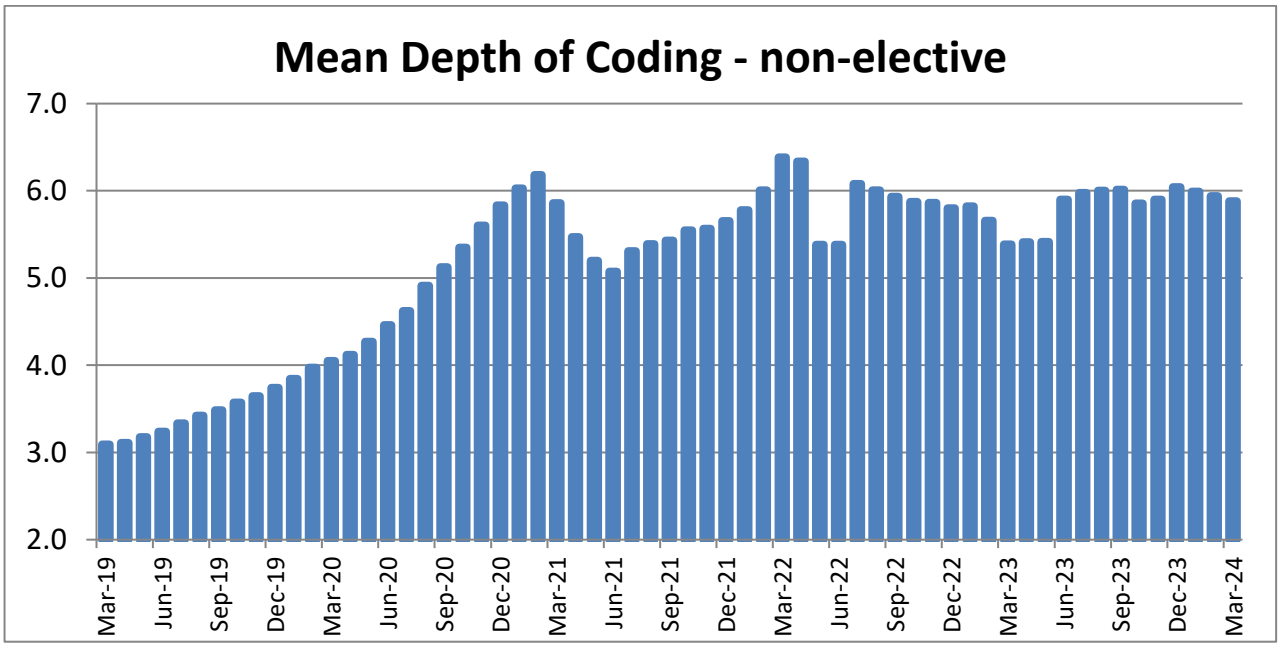


2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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), and subsequent months show it has stabilised at around 6.0 – in line with the national average for non-elective admissions. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly. DCHFT mean depth of coding for elective admissions is slightly below the England Average at 5.3 (compared to 6.0).

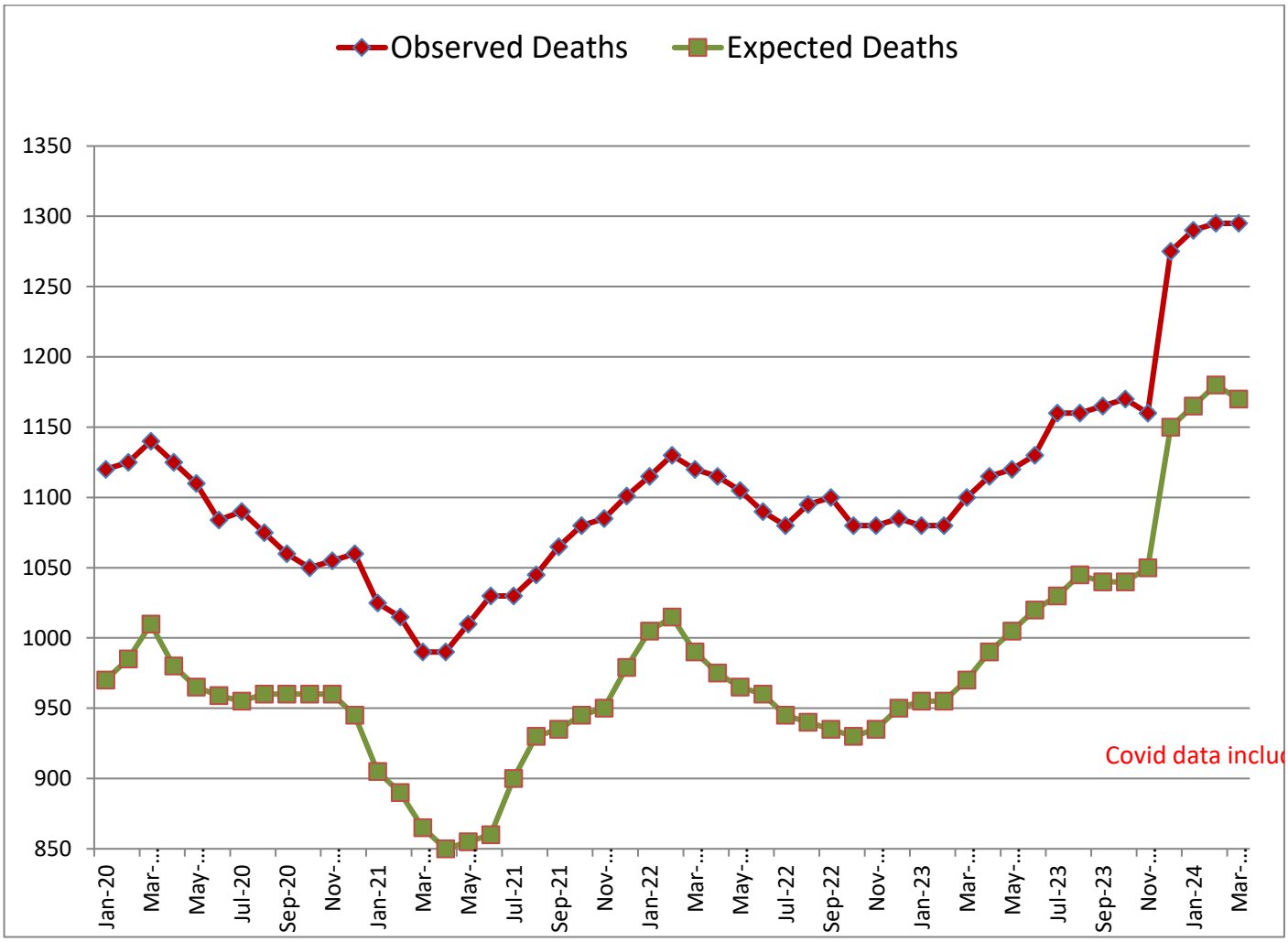
DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.2 (England average 13.3).

Deep dive into end of 2023 figures conducted to check if the limited measures introduced for coding in some specialities (i.e. coding from EDS, DPR and ICE only) had affected our mortality statistics – to date, they have not. This is re-assuring in light of our unsuccessful recruitment attempts for the coding team. Currently there are three vacancies in the team.



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 January 2020 to December 2023), 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 1,000 per 12 months. The latest figures include all covid-related data, hence the increase of around 100 in the 12 months to December 2023. This quarters observed deaths are 1295 with expected deaths at 1180.



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Hospital 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.

HAT (hospital Acquired Thrombosis) readmission audit results:

A Whole year review from Apr 2023 to March 2024 is in progress, with a full comparative report for years 2022, 2023 and 2024 to provide an indepth understanding expected in the next few months.

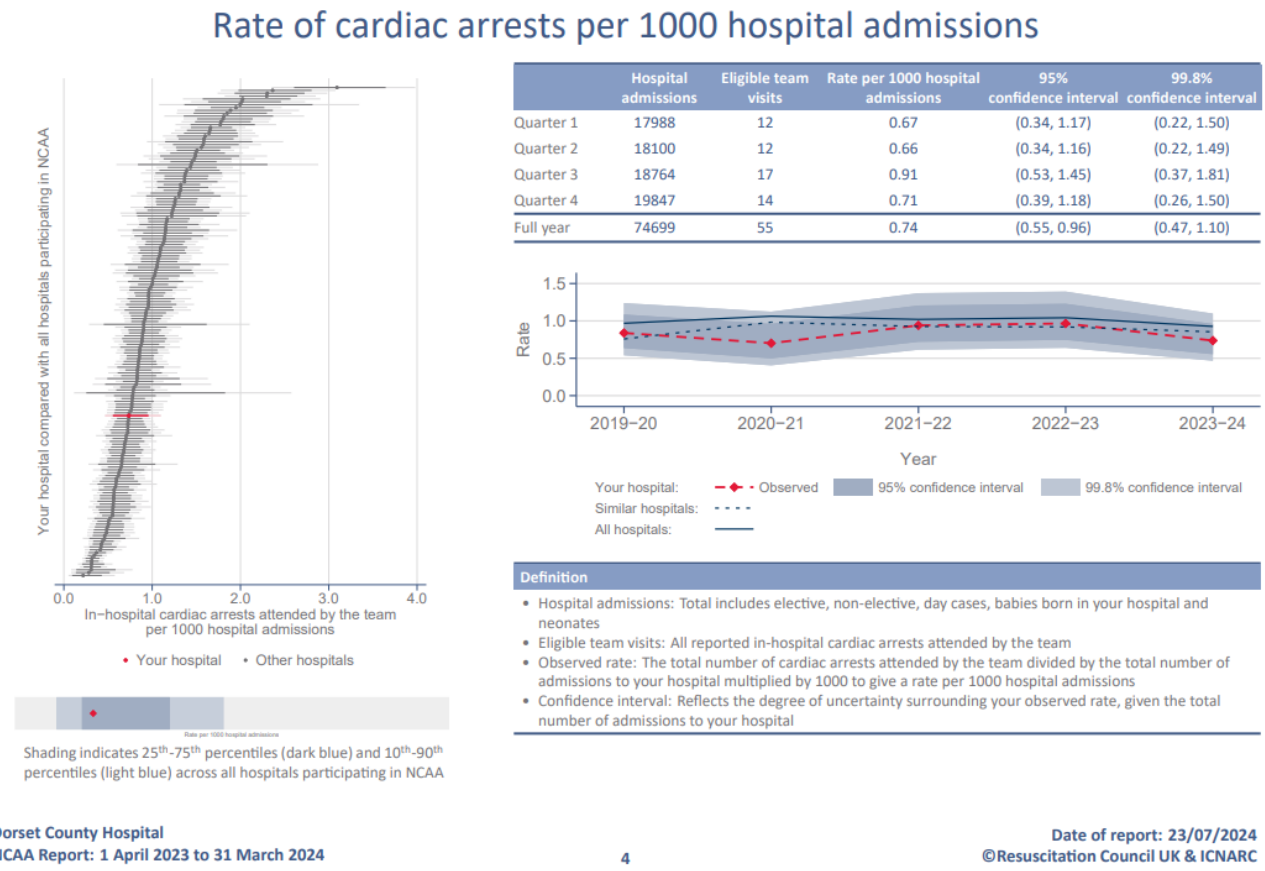
Currently only HAT readmissions are captured. There is ongoing work with BI team to capture all HATs during their index admissions.

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

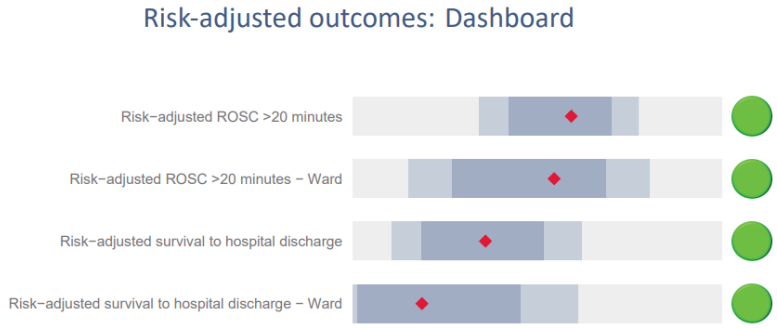
The national Cardiac Arrest audit for DCH including data from 1 April 2023 to 31 March 2024 was published on 23/07/24. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

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.



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

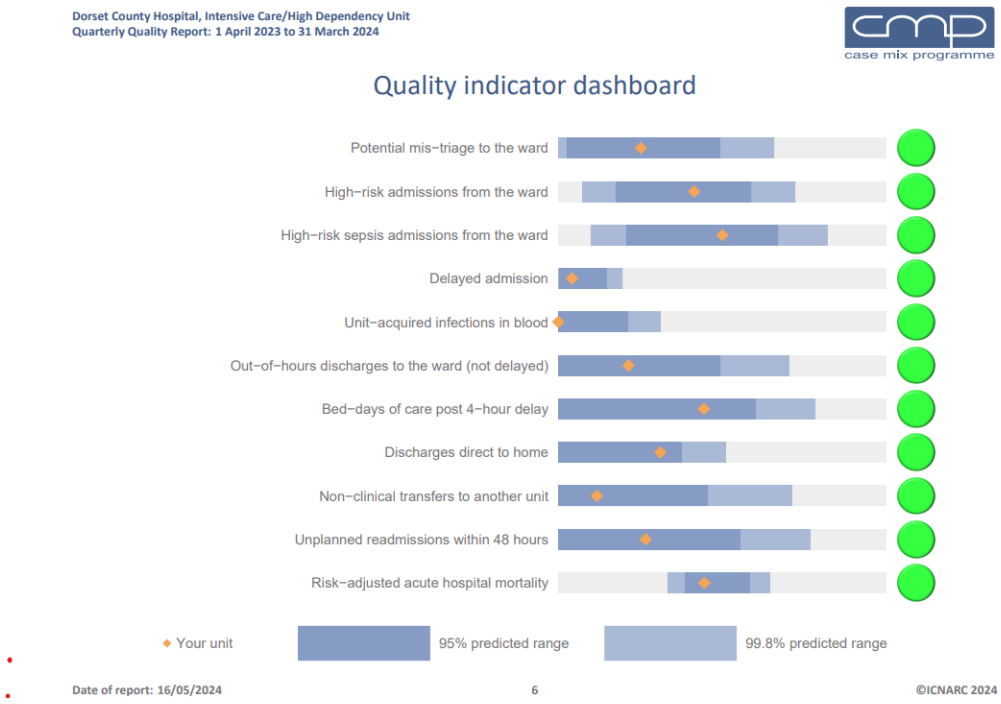
a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator.



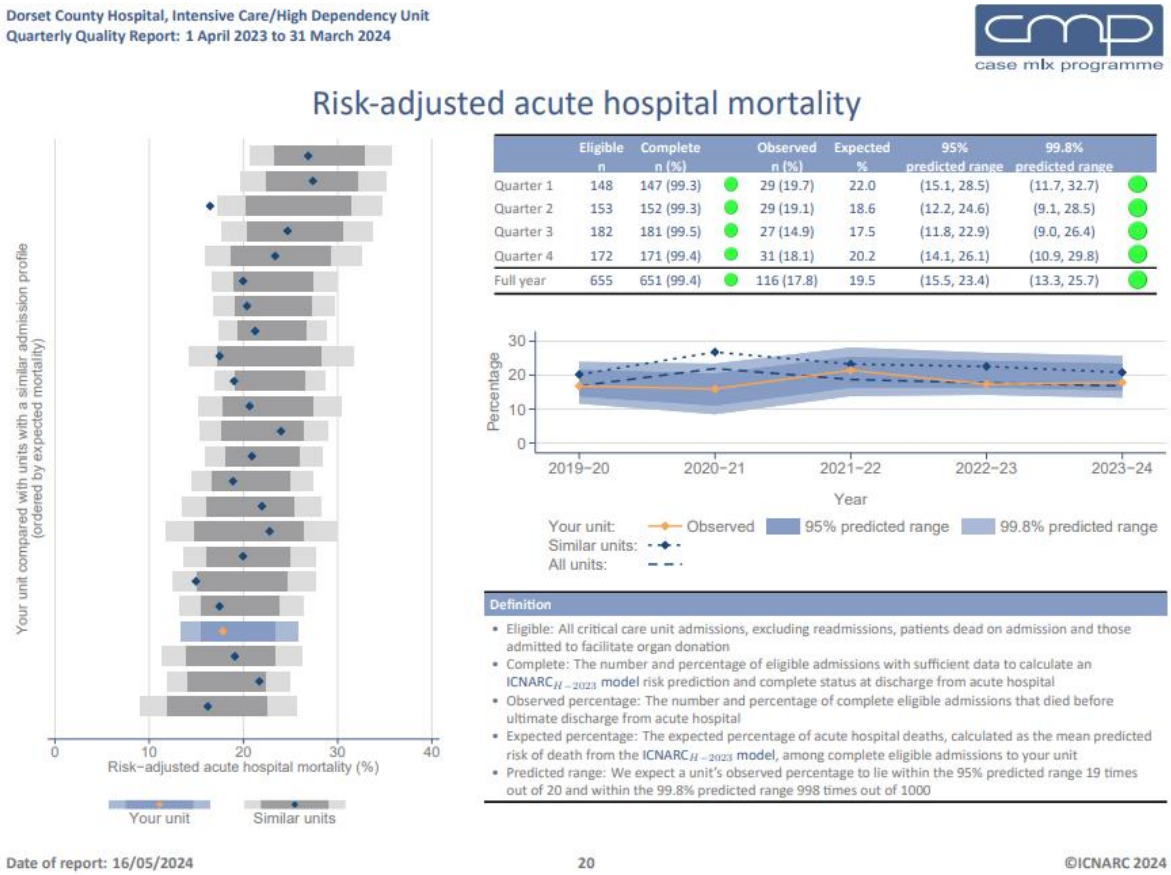
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.

3.3 ICNARC Intensive Care survival data for financial year 1 April 23- 31 March 24; n = 679 patients.

All indicators remain in the GREEN area.



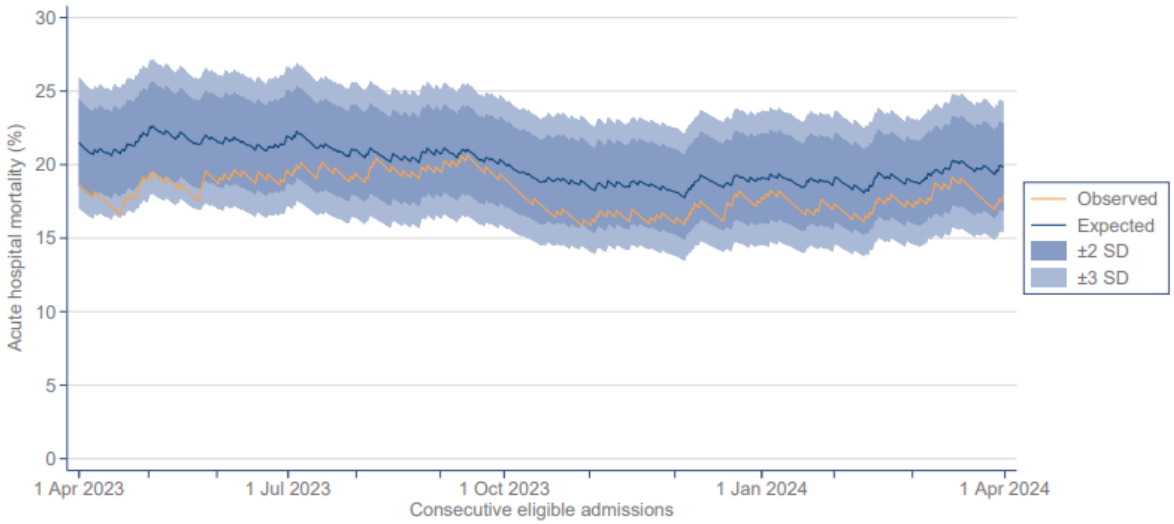
The charts below show the "risk-adjusted acute hospital mortality" following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.



These results are well within the expected range.

case mix programme

Risk-adjusted acute hospital mortality (EWMA plot)

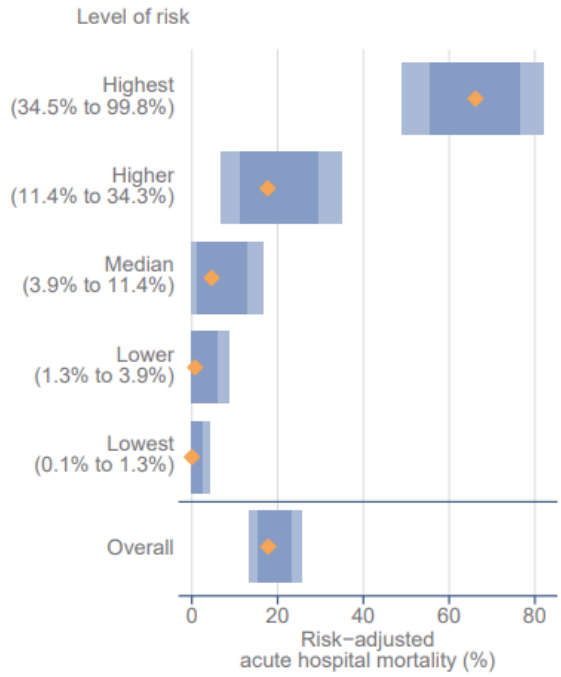


Explanation

- The Exponentially Weighted Moving Average (EWMA) plot shows the trends in observed and expected acute hospital mortality in your unit for the time period of the report
- Expected acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- The plots are updated after each consecutive eligible admission and points are 'exponentially weighted' – giving a larger weighting to the most recent admissions to smooth the appearance of the lines
- The blue shaded areas of the plot represent 2 and 3 standard deviations (SD) above and below the expected line
- If the observed line is above the blue shaded areas, this means the observed acute hospital mortality is significantly higher than expected
- If the observed line is below the blue shaded areas, this means the observed acute hospital mortality is significantly lower than expected

case mix programme

Risk-adjusted acute hospital mortality (by predicted risk)



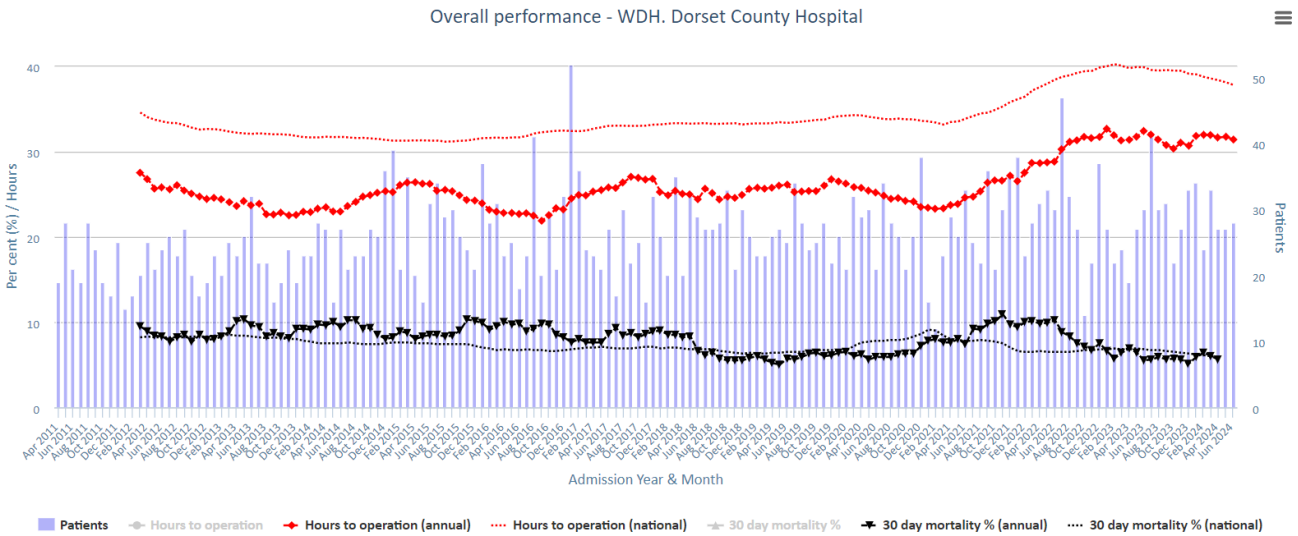
Level of risk	N	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Highest	130	86 (66.2)	66.6	(55.4, 76.5)	(49.1, 82.1)	
Higher	130	23 (17.7)	20.6	(11.3, 29.4)	(6.9, 35.1)	
Median	130	6 (4.6)	7.1	(1.2, 12.7)	(0.0, 16.8)	
Lower	130	1 (0.8)	2.5	(0.0, 5.9)	(0.0, 8.7)	
Lowest	131	0 (0.0)	0.7	(0.0, 2.5)	(0.0, 4.4)	
Overall	651	116 (17.8)	19.5	(15.5, 23.4)	(13.3, 25.7)	

Explanation

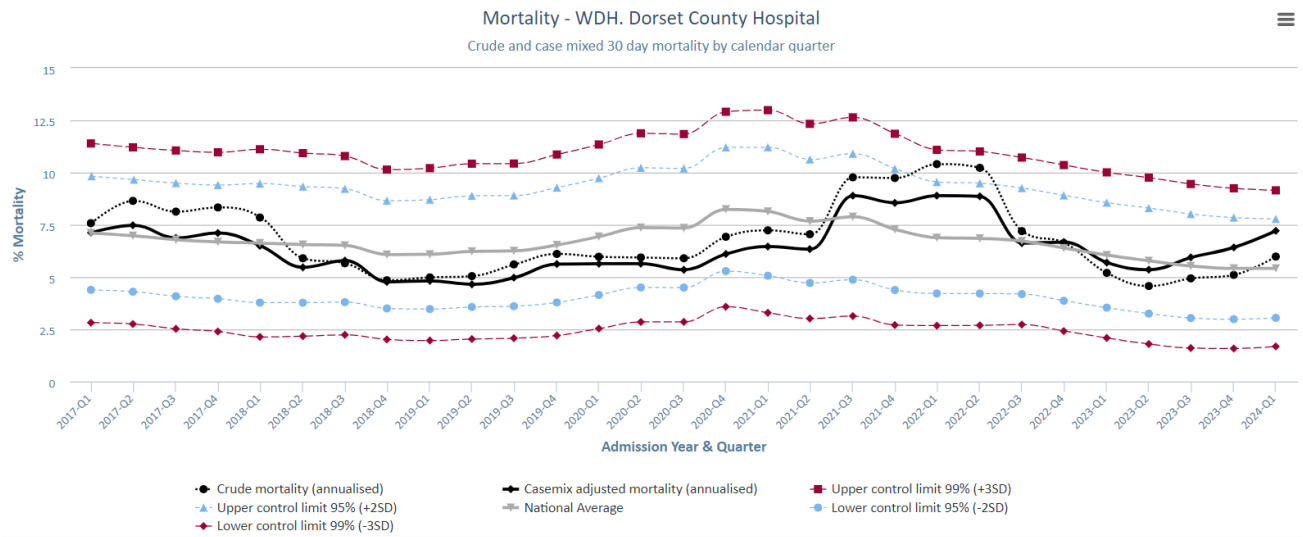
- Risk-adjusted acute hospital mortality (by predicted risk) is designed to help identify patient subgroups in which acute hospital mortality is higher (or lower) than expected
- Admissions are divided into 5 equal-sized groups (or 3 if fewer than 250 complete eligible admissions are available), according to their predicted risk of acute hospital mortality
- N is the number of complete eligible admissions (see Risk-adjusted acute hospital mortality)
- Predicted acute hospital mortality is calculated from the ICNARC$_{H-2023}$ model
- If observed acute hospital mortality is higher than predicted overall, then this analysis may help to identify patient subgroups driving that elevation; if acute hospital mortality is within the predicted range overall, then this analysis may still identify subgroups in which mortality is higher or lower than expected

Date of report: 16/05/2024 22 ©ICNARC 2024

3.4 National Hip Fracture database for Q1



'Hours to operation' remains significantly better than the national average with 30 day mortality in line with the national average.



3.5 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.

Lingering issues exist within website and some incomplete data mean that there is no new information of relevance to mortality for Q1.

3.6 Getting it Right First Time; reviews in Qtr 1

Since the last LfD report, GIRFT have conducted the following reviews:

Diabetes 01/05/24

Head and Neck Cancer 21/05/24

Action plans for GIRFT reviews are presented to the Clinical Effectiveness Committee

3.7 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 whilst awaiting the recreation of the website.

3.8 Readmission to hospital within 30 days

A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process.

Following concerns regarding data accuracy, validation work is complete with the creation of a new dashboard to monitor both re-admission but more importantly quality aspects around re-admission with potential QI opportunity.

No new data for Q1.

3.9 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. Child death data release 2023 | National Child Mortality Database (ncmd.info)

NCMD publications of note for 2024 Q1:

a) https://www.ncmd.info/publications/child-death-learning-disability-autism/ Data April 2019 – March 2022 published July 2024
Recommendations with implications for DCH and partners -

i) Ensure reasonable adjustments are discussed with and provided for all children with a learning disability, autistic children, and where necessary their families and carers, and that the details of these needs are appropriately captured in the "reasonable adjustments digital flag" in their clinical record. Action: all healthcare professionals

ii) Ensure "Was not brought" policies recognise and meet the needs of the complex lives of children with a learning disability, autistic children and their families, and that they support effective attendance at appointments with suitable safeguarding and escalation in place where needed. Action: Integrated Care Boards

iii) Ensure increased focus to ensure that children and young people are not waiting inappropriately long times for autism assessment, in line with NICE and NHS national framework and operational guidance for autism assessment services. Action: Department of Health & Social Care

iv) Ensure that autistic children, and those waiting for an autism assessment, have timely access to appropriate support with mental health services, including talking therapies. Services provided should recognise the importance of post diagnostic support to these groups. Action: Commissioners of mental health services

b) Child drowning deaths in England (ncmd.info) Data April 2022 – March 2023 published 22 July 2024

There were 16 (39.0%) deaths due to drowning of children aged under 5 years, 17 (41.5%) aged 5-14 years and 8 (19.5%) aged 15-17 years. When adjusting for the population of children within these age groups, drowning rates are higher for children under 5 (5.22 per 1 million children) as well as those aged between 15 and 17 years (4.03 per 1 million children).
The highest proportion of child drowning deaths occurred in inland open water, such as lakes and rivers (48.8%, n=20). There were 10 (24.4%) deaths that occurred in the bath at home, and 6 (14.6%) child drowning deaths in 'other residential' water, including 3 in residential hot tubs. Coastal deaths were included in the 5 other (12.2%) deaths.
In 90.0% (n=36/40) of drowning deaths the child was not being supervised by an adult at the time of their death. This included all deaths where the drowning occurred in the bath (n=10), as well as those in 'other residential' water (n=6), such as hot tubs.

Local learning from child deaths (CDOP) mirrors national learning & the annual report was summarised at HMG (17/07/24) by the designated doctor for child deaths for Dorset:

1. A need for improved process for the transfer of tertiary neurology care when a family move to a new area.
2. A need for improved funding for paediatric palliative care to ensure adequate consultant cover and nursing capacity to deliver end of life care in the community.
3. Review of CHC funding and Personal health budgets needed to ensure families have the financial support they need at times of crisis and are not overwhelmed by the bureaucratic complexity of the systems.
4. The notification pathway following a child death has been reviewed and updated to ensure it is comprehensive and efficient.
5. Patients with open access should be offered a physical assessment if the parents are concerned about them. Open access policy is being reviewed to ensure advice is discussed with someone of sufficient seniority
6. Telephone discussions with families must be documented. Open access policy is being reviewed to ensure standard documentation is in place and used by all staff.
7. Privacy and dignity during critical care is important. A privacy screen should be used where necessary and staff who have no role in the resuscitation should not be in the vicinity.

8. Process for seeking feedback from bereaved families needs to be reviewed (raised with Patient Experience Team).

3.10 MBRRACE data:

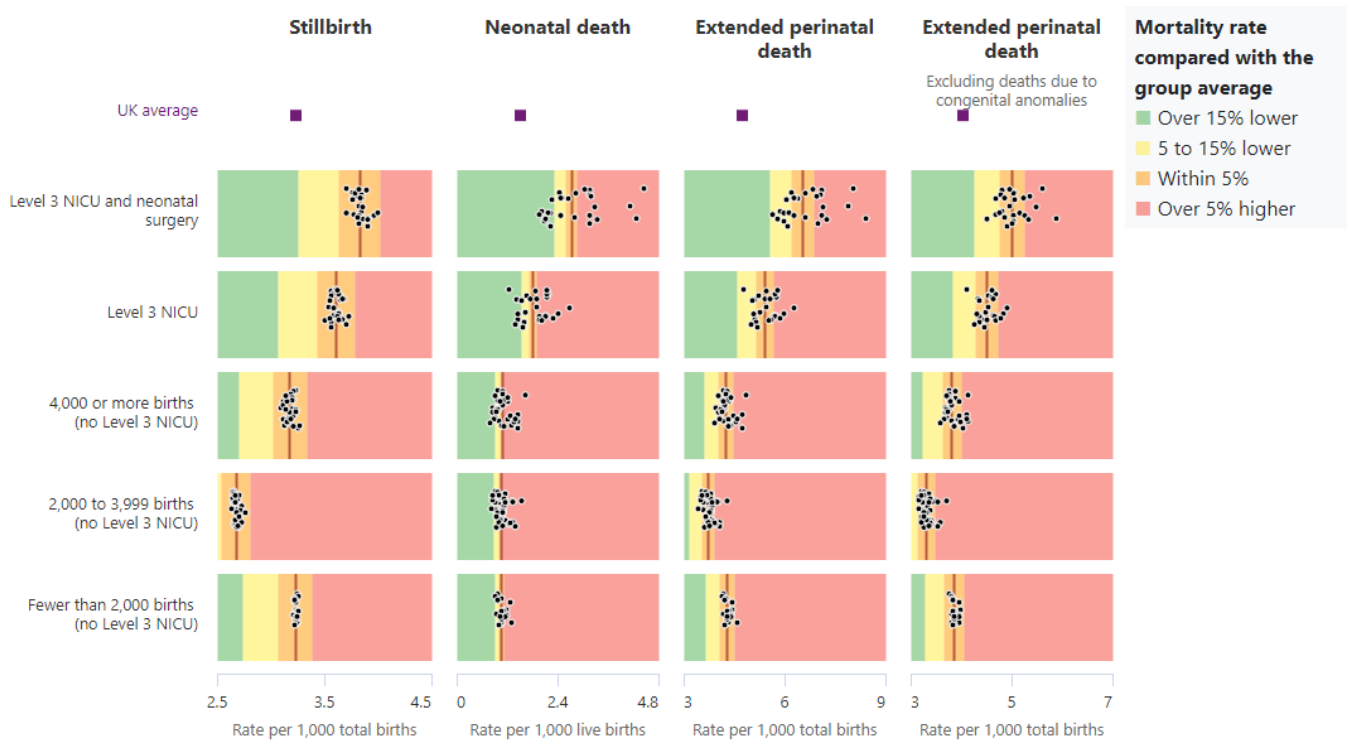
MBRRACE Perinatal Mortality Surveillance UK perinatal deaths of babies born in 2022 (state of the nation report): Published July 2024
https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/
This is the tenth MBRRACE-UK Perinatal Mortality Surveillance Report. The report is divided into five sections: perinatal mortality rates in the UK; mortality rates for Trusts and Health Boards; mortality rates by gestational age; mortality rates by ethnicity and socio-economic deprivation; and a description of the causes of perinatal death.

Key messages-

- **Extended perinatal mortality rates** decreased across the UK in 2022 (UK extended perinatal mortality rate: **5.04 per 1,000** total births) after a rise in 2021, although rates remain higher than both 2019 and 2020. For the purposes of MBRRACE-UK reporting, extended perinatal death refers to all stillbirths and neonatal deaths.
- Compared with rates in 2021, **stillbirth rates per 1,000 total births** in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: **3.35 (UK)**; 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the **neonatal mortality rate per 1,000 live births** in England and Wales compared with 2021: **1.69 (UK)**; 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).
- Stabilised & adjusted neonatal mortality rates continued to show wide variation, with just 21.5% of Trusts and Health Boards falling within 5% of their comparator group average.

To account for the wide variation in case-mix, Trusts and Health Boards were classified hierarchically into five mutually exclusive comparator groups, based on their level of service provision. In order to compare Trusts and Health Boards more fairly, stabilised & adjusted mortality rates were calculated and colour-coded according to the variation from their respective comparator group average. Where there is only a small number of births in an organisation it is difficult in any one year to be sure that any extreme value seen for the crude mortality rate is real and not just a chance finding. A stabilised rate allows for the effects of chance variation due to small numbers.

Figure 2: Stabilised & adjusted stillbirth, neonatal and extended perinatal mortality rates for Trusts and Health Boards by comparator group: United Kingdom and Crown Dependencies, for births in 2022



Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Jersey.

Dorset County Hospital NHS Foundation Trust

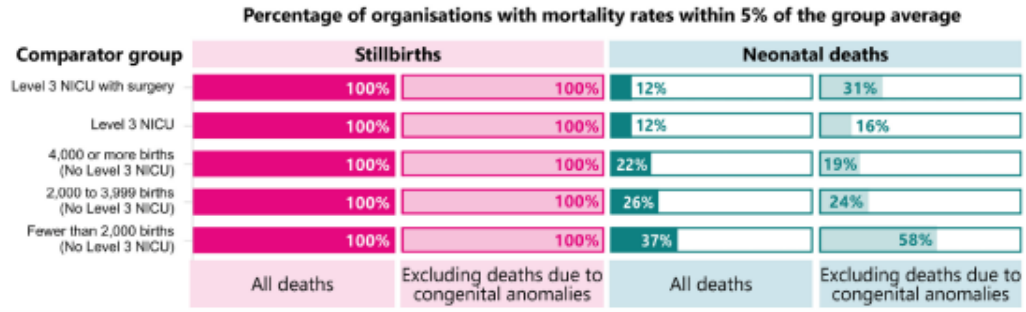
Year	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate
2018	1,699	-	2.32	(1.50 to 3.22)	-	0.52	(0.18 to 1.10)	2.35	2.84
2019	1,624	-	3.13	(2.18 to 4.05)	-	0.99	(0.50 to 2.04)	3.08	4.12
2020	1,481	2.70	2.59	(1.75 to 3.87)	2.03	0.99	(0.53 to 1.90)	4.73	3.58
2021	1,573	-	2.73	(1.77 to 4.04)	-	0.50	(0.17 to 0.97)	3.18	3.22
2022	1,497	2.67	3.23	(2.40 to 3.79)	2.01	1.19	(0.60 to 2.38)	4.68	4.43

VIBRACE data
SW figures from the Perinatal Mortality data viewer

Mortality rate compared with the group average
Over 15% lower | 5 to 15% lower | Within 5% | Over 5% higher
Suppressed

Organisation	Stabilised and adjusted figures 2022 information: Neonatal deaths (per 1000 live births)	Stabilised and adjusted figures 2022 information: Stillbirth (per 1000 live births)	Stabilised and adjusted figures 2022 information: Extended perinatal (per 1000 live births)	Crude mortality figures 2022 information: Neonatal deaths (per 1000 live births)	Crude mortality figures 2022 information: Stillbirth (per 1000 live births)	Crude mortality figures 2022 information: Extended perinatal (per 1000 live births)	Total Number of births	Type of unit
University Hospitals Bristol & Weston	4.12	3.82	7.89	4.35	3.47	7.80	4616	Level 3 NICU and Neonatal surgery
North Bristol	2.03	3.51	5.54	2.05	1.49	3.54	5371	Level 3 NICU
University Hospitals Plymouth	1.75	3.68	5.41	1.70	4.79	6.48	3551	Level 3 NICU
Royal Devon University Hospitals	1.27	3.21	4.48	1.46	3.54	4.99	4808	4000 or more births
Gloucestershire Hospitals	1.22	3.12	4.33	1.26	1.98	3.24	5556	4000 or more births
Royal United Hospitals Bath	1.10	3.12	4.21	0.94	1.41	2.34	4268	4000 or more births
Somerset FT	1.03	3.15	4.18	0.71	2.14	2.85	4207	4000 or more births
University Hospitals Dorset	0.86	3.09	3.94			1.25	4012	4000 or more births
Great Western	1.30	2.67	3.97	1.87	2.13	4.00	3751	2000-3999 births
Royal Cornwall	1.09	2.71	3.80	1.08	3.22	4.29	3731	2000-3999 births
Salisbury FT	0.91	2.66	3.58			1.38	2175	2000-3999 births
Dorset County	1.19	3.23	4.43	2.01	2.67	4.68	1497	Under 2000 births
Torbay & South Devon	0.91	3.26	4.15			4.21	1902	Under 2000 births

2. There was wide variation in neonatal mortality rates



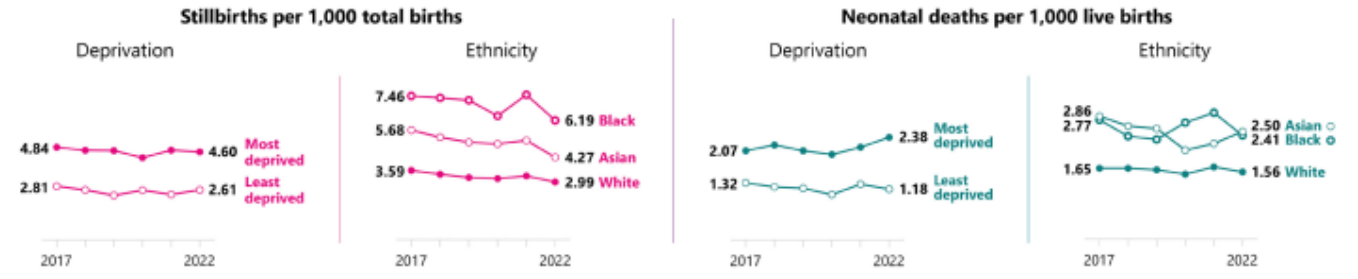
What is a stillbirth or neonatal death?

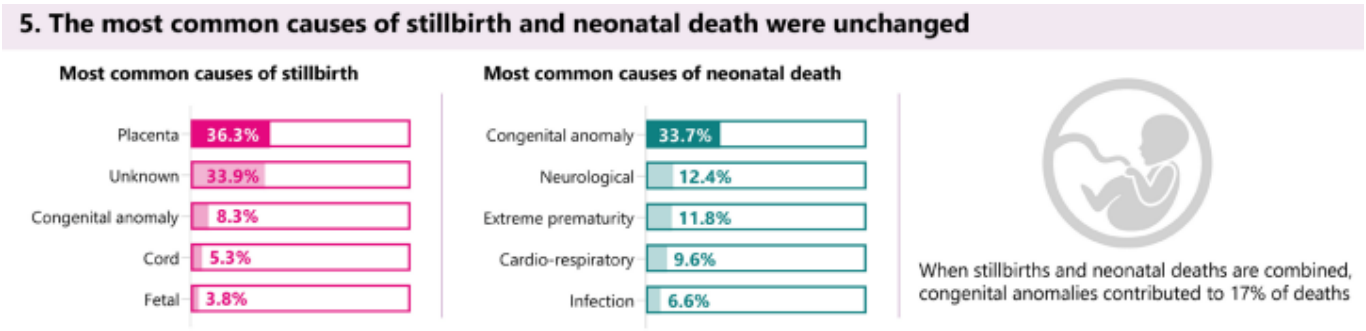
A **stillbirth** is the death of a baby before or during birth once a pregnancy has reached 24 completed weeks.

A **neonatal death** is a baby born at any gestation who lives, even briefly, but dies within 28 days of birth.

All rates in this report are for babies born from 24 completed weeks and include deaths due to congenital anomalies, unless otherwise stated.

4. Despite recent improvements, inequalities in mortality rates by deprivation and ethnicity remain





The maternity and neonatal teams at DCH use the BAPM Perinatal Optimisation Pathway to support improving outcomes for preterm babies. Compliance with PERIPrem is monitored at Perinatal M&M meetings when presenting cases.
https://www.bapm.org/pages/perinatal-optimisation-pathway
https://www.healthinnowest.net/our-work/transforming-services-and-systems/periprem/

3.11 National Perinatal Mortality Review tool

Data included in the Maternity safety report to Quality Committee in line with Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) standards.

2 incidents relating to care provided by DCH were reported to MBRRACE-UK via the PMRT in Quarter 1. The hospital within which the baby dies is responsible for reporting cases therefore 1 case was reported by DCH and 1 case was the responsibility of another Trust where the baby died. This mother was booked and cared for by DCH in the antenatal period and transferred in the antenatal period to a tertiary centre due to the gestation of the pregnancy. DCH are involved with the PMRT process and review for this baby, but the tertiary centre leads the reviews.

Neither case met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI) and no concerns have been raised with the notification and surveillance submissions and the current reporting process is to continue.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

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

1. TEP policy update arising from the task group:

   The main changes proposed for discussion are:

   - That all patients have a TEP completed on admission along with a resuscitation decision. There are circumstances when this can be deferred for up to 48 hours.
   - A decision for full escalation and attempt at resuscitation can be documented on the new TEP form – removing the uncertainty as to whether decisions around resus or 'allow a natural death' have been made or considered.

2. Frailty:

   - Use of the term frailty of old age on medical death certificates and whether this has or will lead to a reduction in other medical diagnoses and thus impact on expected deaths

3. Review of incidents of elderly patients with a long stay in ED and prescribing of anticipatory meds

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. Following M&M meetings any learning and actions identified from the cases discussed are highlighted and information collated on an overview slide which is shared at their monthly Care Group meeting and the Divisional Business & Quality Governance meeting. Records of action plans and learning identified are available across departments.

Examples of Learning and Actions from M&M Meetings:

Paediatrics
Learning & actions:

- CCLG have guidelines around referral timeliness/requirements
- Idiosyncratic side effects of chemotherapy agents must be known and considered during assessment.
- Pathways for CYP on active treatment for malignancy discussed
- Excellent recognition of progressive neurology with appropriate escalation and timely intubation
- Professional curiosity vs rationalising investigations
- Communication challenges with non-English speaking families, especially in emergency situations.
- Advice from tertiary centre vs clinical assessment of child in front of you.
- Delays in imaging reporting impacting clinical decision making and treatment initiation.
- Challenges of managing extreme parental anxiety whilst advocating for CYP.
- Ceilings of care and professional unease with decisions.

Anaesthetics

1. Theatre Coordinator to remain contactable at all times to facilitate urgent arrangements or patients requiring immediate intervention in this case a patient needing to go to theatre for a PPH.
2. TIVA pump failure: remain diligent and replace pumps asap.
3. Do not use relatives as translators as per the guidance as can lead to distress and misinformation being communicated.
4. Antibiotic prescribed for incorrect patient. No harm as not given but reflected on how easy it is to pick incorrect patient on EPMA. Highlighted need to double check patient on EPMA when prescribing. Are there any systems that could be put in place on EPMA to make this error less likely to recur?
5. No latex free sterile gloves available in correct size for sterile procedure in latex allergic patient. Stores staff were on leave – need to allow for cover so stock not missing.
6. Incorrect strength of ketamine signed for in CD book. Ensure not just correct drug but also correct strength signed for.
7. No ODP available for maternity brief for elective section due to cardiac arrest on the wards. Complex section was then delayed which was tricky as no anaesthetic consultant in maternity in the afternoon. Highlights the need for dedicated maternity ODP and not bleep holder – trial of this in the daytime has shown it is useful.
8. Penicillin allergy recorded as penicillamine. Recurring error on EPMA. Reminded to ensure correct allergy noted and whether drug group or drug itself. Would be good if EPMA could have something in place to reduce this risk.

General and Colorectal Surgery

1. Communication challenges with non-English speaking families, especially in emergency situations. Advice from tertiary centre vs clinical assessment of child in front of you. Delays in imaging reporting impacting clinical decision making and treatment initiation. Challenges of managing extreme parental anxiety whilst advocating for CYP. Ceilings of care and professional unease with decisions.

- Good management of the complication (second CEPOD theatre opened).

- Unusual complication. Cause of megacolon not clear ? Ischaemic. Perforation managed successfully.

Elderly Care & Stroke

- Learning: The importance of updating patients' families on their medical condition, particularly if they are unable to come to the hospital (Covid).

6.0 LEARNING FROM CORONER'S INQUESTS Q1

During the period 01.04.2024 to 26.06.2024, 18 inquests were opened. A total of 16 Inquests Hearing were held, some of which will have related to the previous financial year.

For these 16 cases, 30 statements were obtained from clinicians involved in the patient's care.
7 clinicians were called to give live evidence, which gives a percentage of 23% of clinicians who provide a statement being called to give evidence for this period.

No Inquests have progressed to a claim in this period as yet, although we have 1 case that we are expecting to progress via the litigation route. This is the case we received the Regulation 28 (Prevention of Future Deaths) in relation to out of hour access to interventional radiology. This has now been redirected to NHS England.

No legal representation was required to support the Inquest process through this period and 1 Pre-Inquest Review was conducted

As of July 2024, HMG will be receiving quarterly reports to triangulate data from inquests and SJRs.

Learning Identified:

- To improve documentation of clinical discussions between provider units
- Review of discussions with families around DNAR decisions
- Lower threshold for scanning neck in older patients with Head injury (NICE)
- Remember possibility of high cervical injury in headache presentations (occipital / craniocervical pain)
- Repeat attenders should be reviewed by a senior clinician

7.0 LEARNING FROM CLAIMS Q1

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 1 FY 24/25.

New potential claims	15
Disclosed patient records	18

Formal claims	11
Settled claims	2
Closed - no damages	1

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 April 2023 – 31 March 2024. The Trust's figure is 1.1057, which is within the expected range using NHS England's control limits.

The DCH internal prediction has been that SHMI will continue to fall gradually over the following three months to around 1.0700 - however this depends on the resources within the coding department. We are aware that our data may become adversely influenced by resource challenges within the Coding Department and a possible under-reporting of 'sepsis' in the written medical record. The clinical coding risk is rated as high on the risk register. The team have implemented strategies for risk mitigation.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH. 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.