Learning from Deaths Report Q4 2023/24

1. Report Details			
Meeting Title:	Board of Directors, Part 1		
Date of Meeting:			
Document Title:	Learning from Deaths Q4 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	15 May 2024	
Quality Committee	21 May 2024	Recommended for approval

3. Purpose of the Paper	To inform the Board of the learning occurring from deaths beingreported, investigated and appropriate findings disseminated throughout the Trust.To also outline additional measures put in place to assure the Trust thatunnecessary 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 110.9. This is slightly decreased from previous at 112.26 We do have re-emerging concerns that our SHMI will become adversely affected by the lack of resources within the clinical coding dept which is resulting in a significant backlog. 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 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 essential to the Trust's ability to assess quality of care. The Coding Dept is expecting to complete the full end of year update to NHSE on time this month (May 2024). The Dept is still short-staffed and depending on 2 agency coding staff to remain up to date. 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.

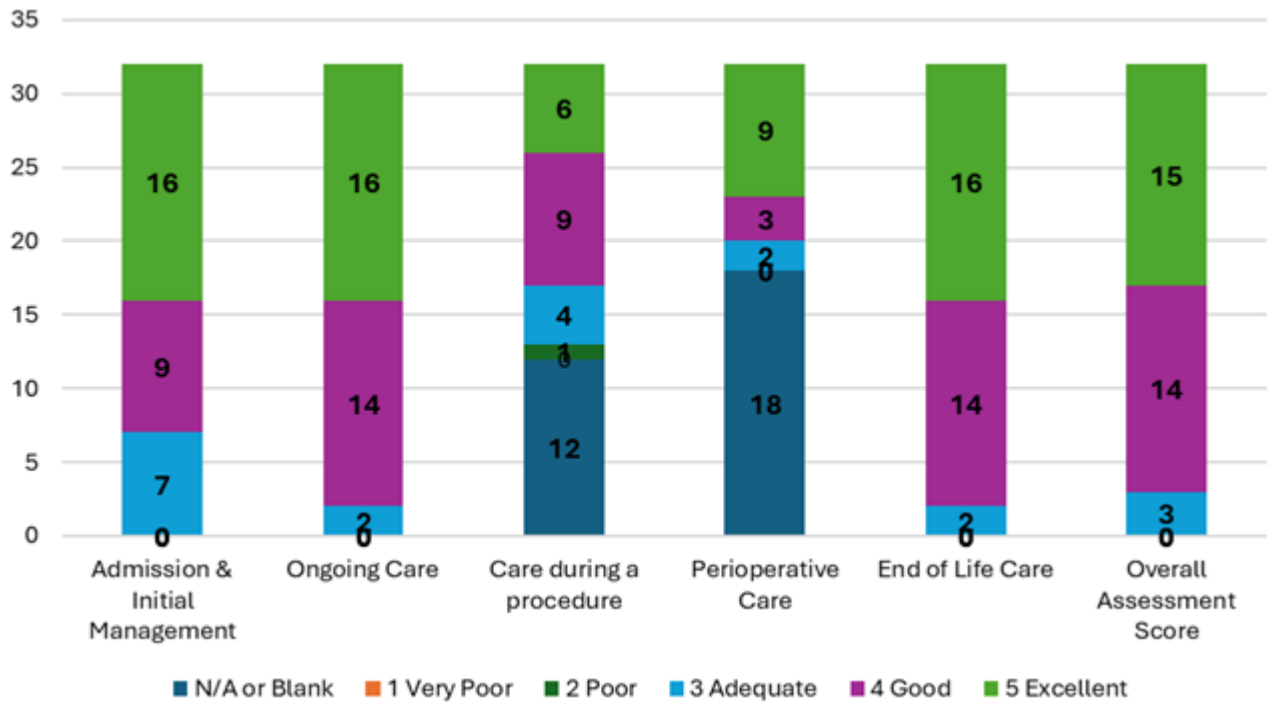
1.1 Family Services and Surgical Division Report - Quarter 4 2023/24 Report

Structured Judgement Review Results:
The Family Services & Surgery Division had 55 deaths in quarter 4, of which 46 that require SJR's to be completed. Within quarter 4 32 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 17/04/2024 is 23:

Feedback from SJR's Completed in Quarter 3:

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	0	12	18	0	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	1	0	0	0
3 Adequate	7	2	4	2	2	3
4 Good	9	14	9	3	14	14
5 Excellent	16	16	6	9	16	15



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	5	13	13

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	1	5	26

Actions:

Following completion of the 32 SJR's, 10 were highlighted as requiring actions.

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

Other actions:
- 2 for review and discussion at Specialty M&M meetings.
- 1 requested second SJR from specific specialty.

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.

Paediatric Mortality for Q4:

6 deaths - Combination of expected and unexpected deaths.

Child Death Overview Panel is Pan Dorset & Somerset to allow appropriate professional challenge and professional curiosity around child deaths in line with national expectations of the number of child deaths that should be reviewed by a CDOP for governance. CDOP also ensures appropriate learning from deaths and informs NCMD of death information to guide national child death data and learning/practice changes.

Ongoing work for improving service provision:
Processes of notification of a death has been streamlined to improve efficiency and timeliness of notification.
Working closely with Coroner for Pan-Dorset approaches and practice consistency.

Good Practice:
Excellent multi-agency response and coordination of support.

Challenges:
Ongoing delays in Child Death Reviews and therefore CDOP reviews due to timing for paediatric PMs

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

In quarter 4 there were 193 deaths, 43 SJR's were requested from these deaths, and 20 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q4			Q1			Q2			Q3			Q4		
	Jan-23	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan-24	Feb	Mar
Deaths	71	61	69	61	60	57	65	58	60	49	41	63	65	59	69
Deaths requiring SJR'S from Month	7	9	11	10	10	14	15	14	18	11	14	13	15	16	12
*Completed SJR'S	1	8	14	5	12	16	2	14	17	20	12	3	7	11	2

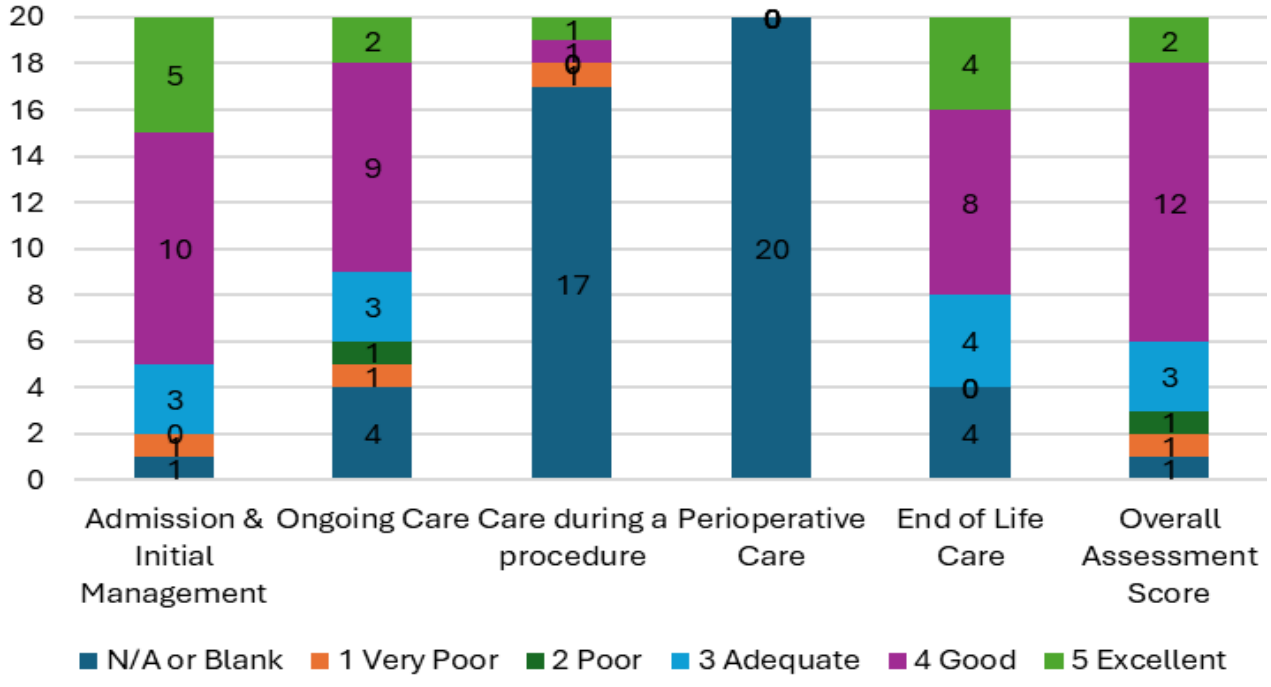
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 22/04/2024 is 52 including outstanding nosocomial reviews:

July	August	September	October	November	December	January
1	5	8	4	9	12	13

Phase score from 20 completed SJR's in quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	1	4	17	20	4	1
1 Very Poor	1	1	1	0	0	1
2 Poor	0	1	0	0	0	1
3 Adequate	3	3	0	0	4	3
4 Good	10	9	1	0	8	12
5 Excellent	5	2	1	0	4	2



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	1	0	4	14	1

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	2	2	16

Actions:

Following completion of the 20 SJR's, 6 were highlighted as requiring actions:

- 1 was consideration for RCA and referred to Hospital Mortality Group (HMG).
- 1 was referred to Hospital Mortality Group (HMG).
- 1 was referred to ENT
- 1 was referred to SWASFT
- 1 referred back to the GP practice
- 1 referred for the acute medical M&M meeting

For further LfD and QIP see section 4.

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

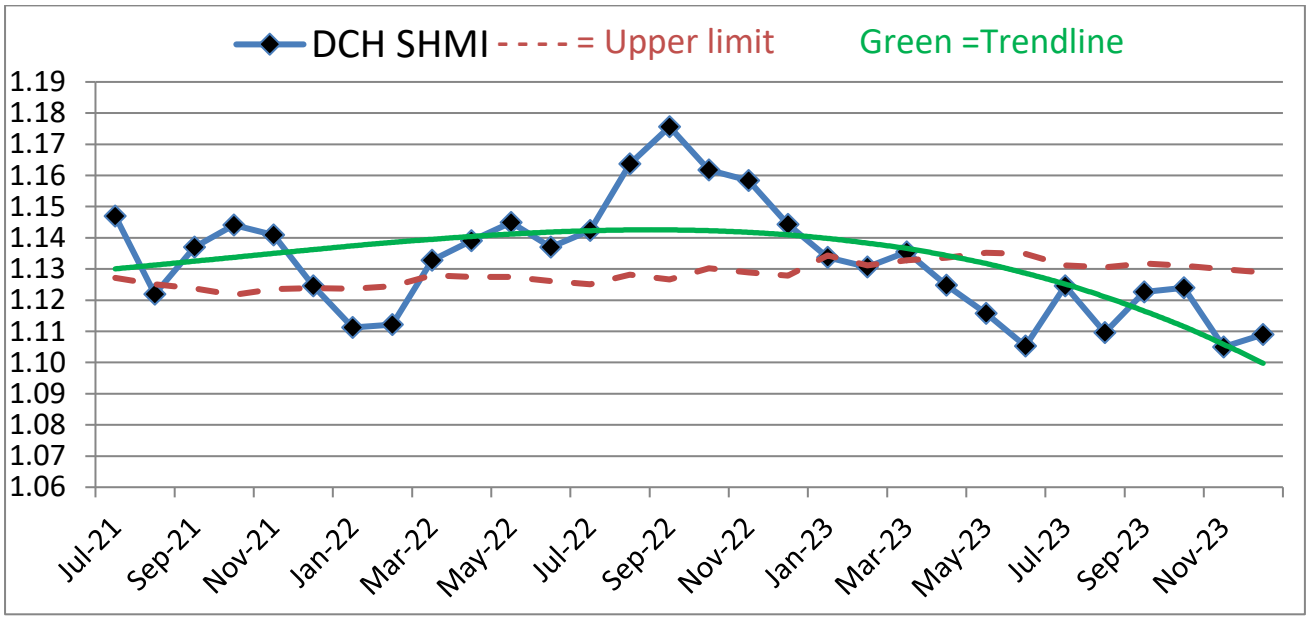
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

From the May 2024 publication onwards, the following changes will be made to the SHMI methodology:

- COVID-19 activity will be included if the discharge date is on or after 1 September 2021
- Hospice sites within non-specialist acute trusts will be excluded
- In the site level breakdown of the data, a SHMI value will only be calculated for a subset of sites
- The methodology for identifying the primary and secondary diagnoses for spells consisting of multiple episodes will be updated
- Activity with an invalid primary diagnosis will be moved to a separate diagnosis group.

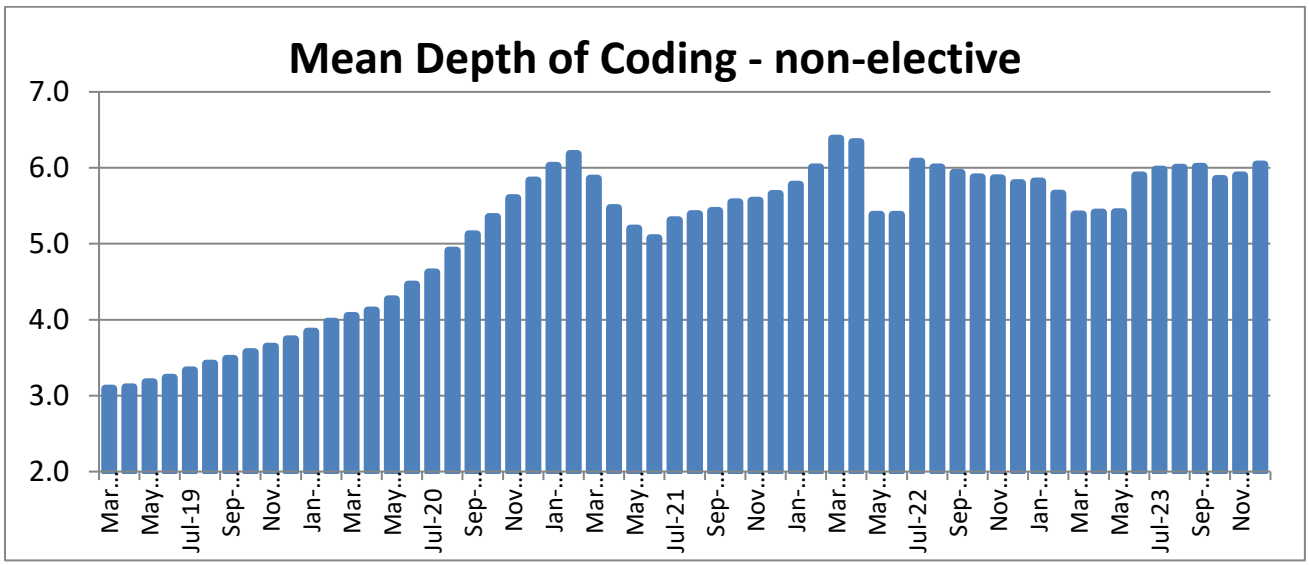
The latest SHMI publication from NHS England is for the period Jan 2023 – Dec 2023. **The Trust's figure is 1.1090 which is within the expected range** using NHS England's control limits.

We are aware that our data continues to be adversely influenced by staffing levels (though mitigations in place) in the Coding Department, and a possible under-reporting of 'sepsis' in the written medical record. Acute and unspecified renal failure is a relatively new alert and is being explored further by divisions. Coding of fluid and electrolyte imbalance/ AKI within medical records is also being reviewed at HMG.



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*."

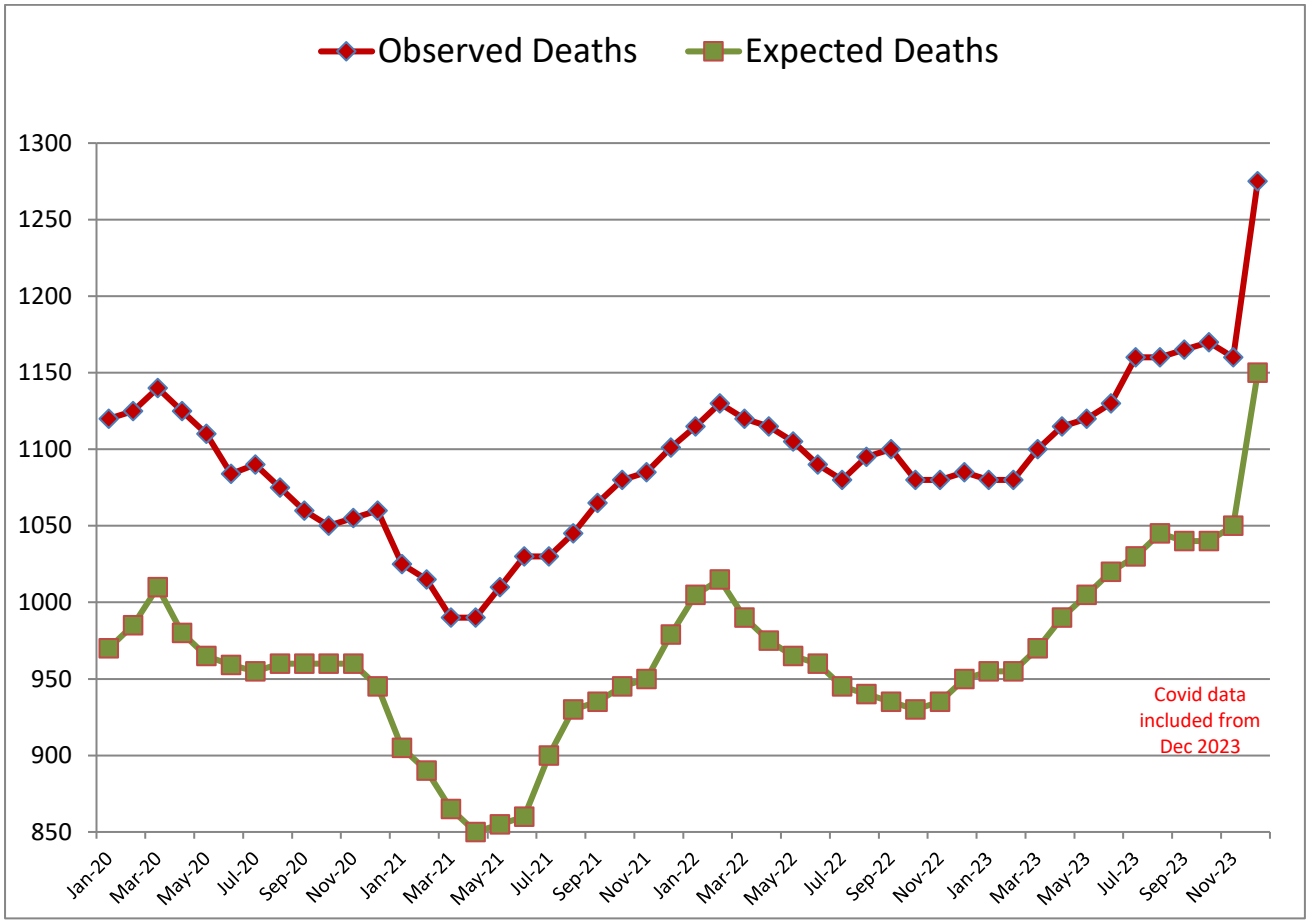
DCH's depth of coding had been improving steadily up to March 2022 (see graph below), and subsequent months show it has stabilised at around 6.0 – slightly above the national average. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly.



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.



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.

Of interest, included is the summary from the Jan-April 2023 HAT (hospital Acquired Thrombosis) readmission audit results:

- 9 readmissions during this period. Incidence is 1.3 per 1000 DCH admissions. GIRFT national average was 2.0 per 1000 hospital admissions. As before PE is the common VTE.
- Nil mortality due to HAT
- There is an increasing trend in HAT due to thromboprophylaxis failure. Current rate is 56% compared to 26% and 34% in the previous 2 audits. This can be considered a healthy trend as it indicates that we are getting better in doing all that we can in terms of VTE prevention, but HAT still occurred despite optimal management.
- HAT due to inadequate prophylaxis (poor care) was 2 of 9 giving 22% - was previously 28% and 58%. Improving but numbers are small, so unclear if significant improvement or not. But trend looks good.
- All potentially preventable HAT incidents are DATIXed for individual teams learning

- Nil specific trends or specialities with HAT incidents – incidents remain random.

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.

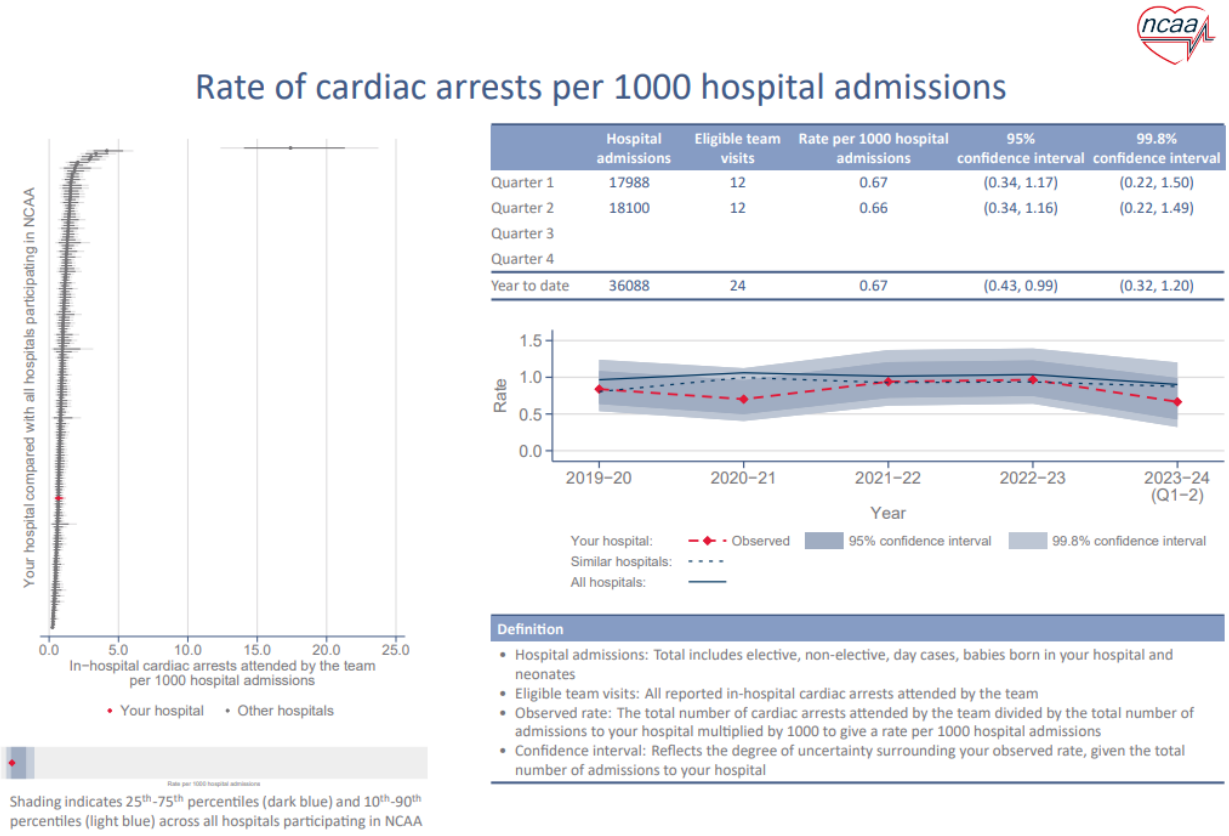
Currently only HAT readmissions are captured. There is ongoing work with BI team to capture all HATs during their index admissions.

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 April 2023 to Sept 2023 (quarters 1+2) was published on 17/01/24. 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.

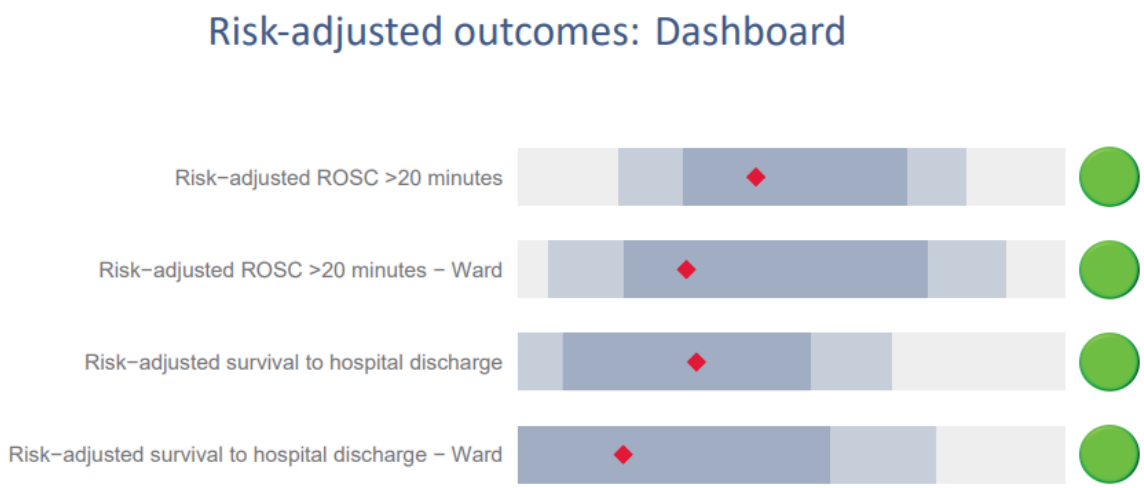
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below the table summarises the past 5 years.



	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	18100	12	0.66	(0.34, 1.16)	(0.22, 1.49)
Quarter 3					
Quarter 4					
Year to date	36088	24	0.67	(0.43, 0.99)	(0.32, 1.20)

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 2 (published 17/01/24).



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.

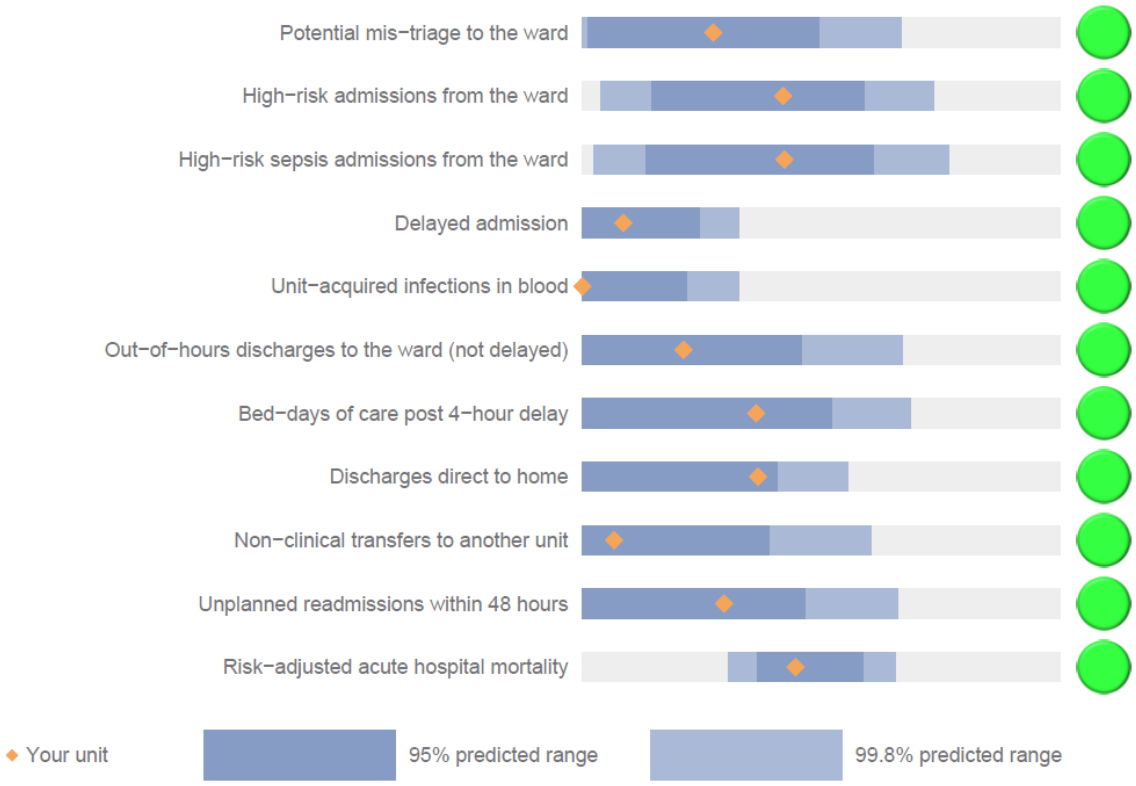
3.3 ICNARC Intensive Care survival data for financial year 2023/24 Q3 (April 23-Dec 23 data); n = 502 patients.

All indicators remain in the GREEN area.

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2023 to 31 December 2023

case mix programme

Quality indicator dashboard

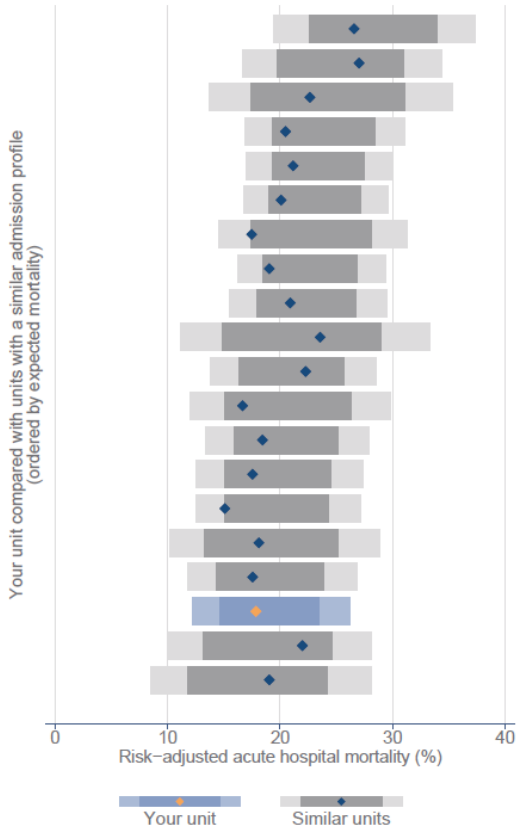


The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit in Q3 2023/24. They compare observed and expected death rates in a similar fashion to SHMI.

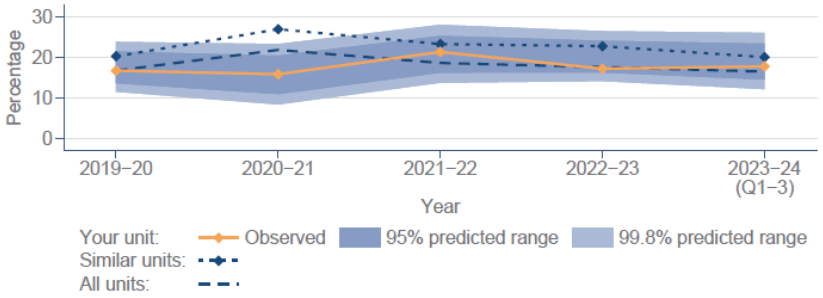
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2023 to 31 December 2023

case mix programme

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	152 (99.3)	●	29 (19.1)	18.6	(12.2, 24.6)	(9.1, 28.5)	●
Quarter 3	182	177 (97.3)	●	27 (15.3)	17.2	(11.5, 22.7)	(8.7, 26.2)	●
Quarter 4								
Year to date	483	476 (98.6)	●	85 (17.9)	19.1	(14.6, 23.5)	(12.3, 26.2)	●



Definition

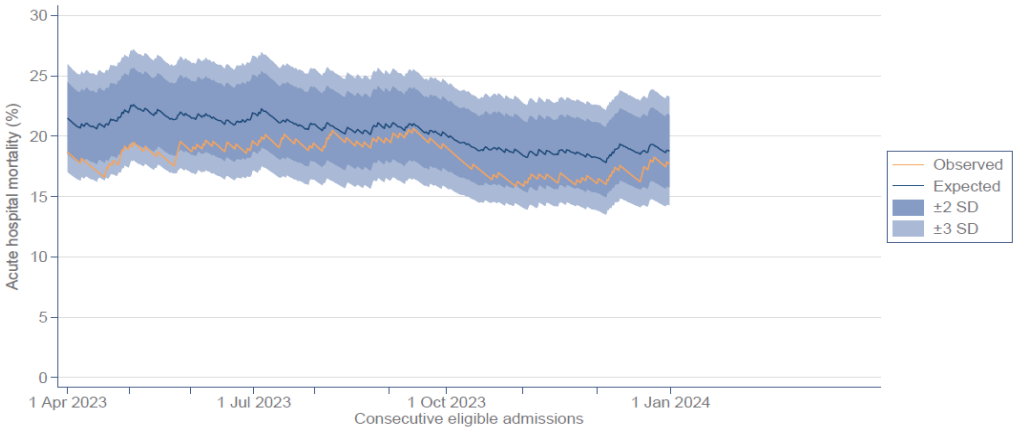
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calculate an ICNARC$_{H-2023}$ model risk prediction and complete status 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

These results are well within the expected range.

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2023 to 31 December 2023

case mix programme

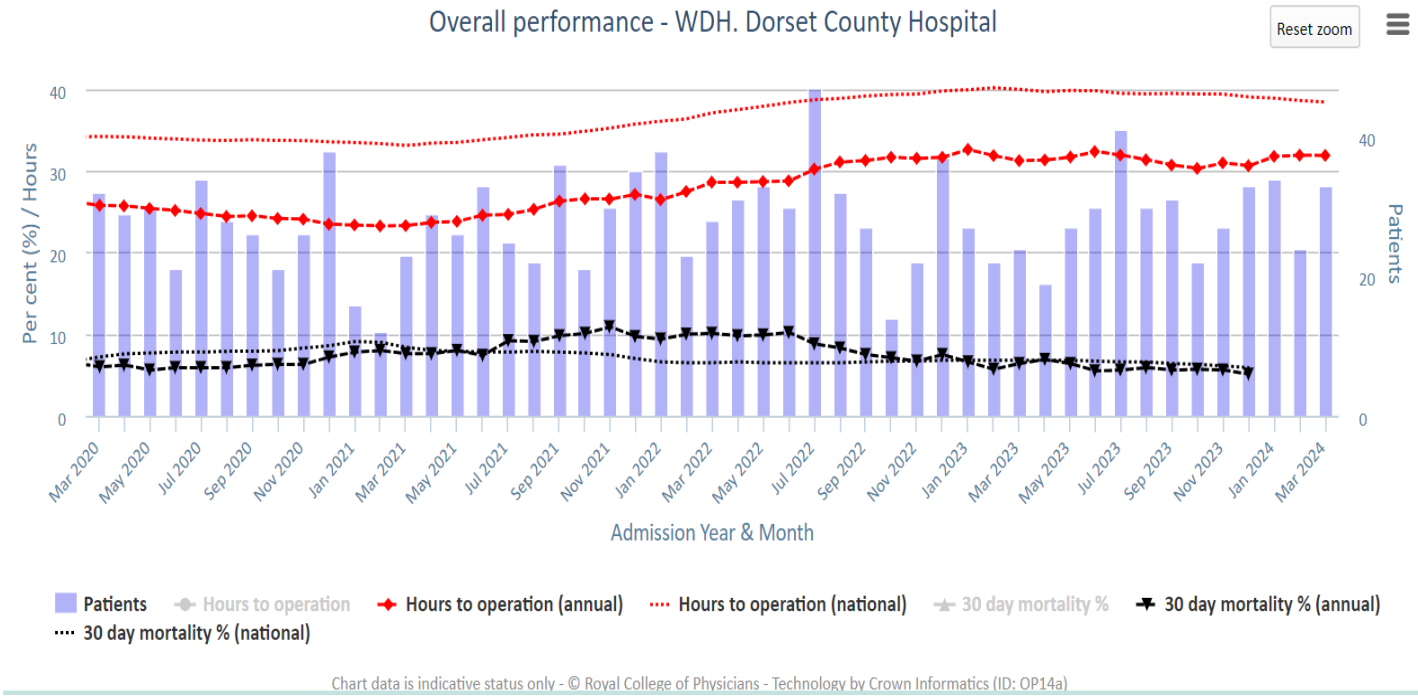
Risk-adjusted acute hospital mortality (EWMA plot)



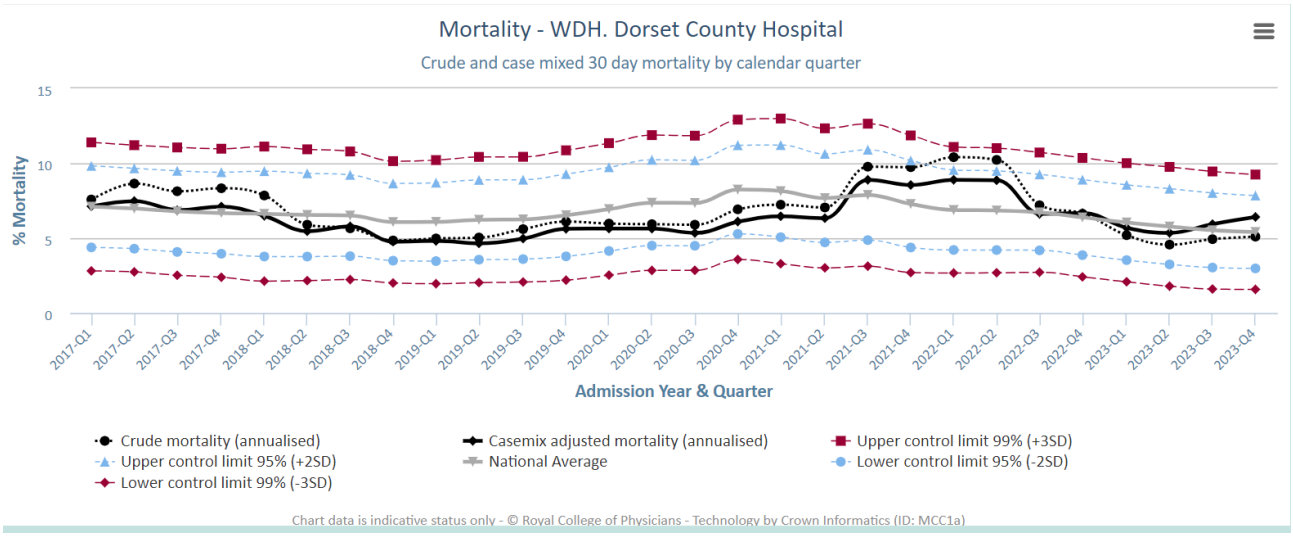
Explanation

- 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

3.4 National Hip Fracture database to Dec 2023



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



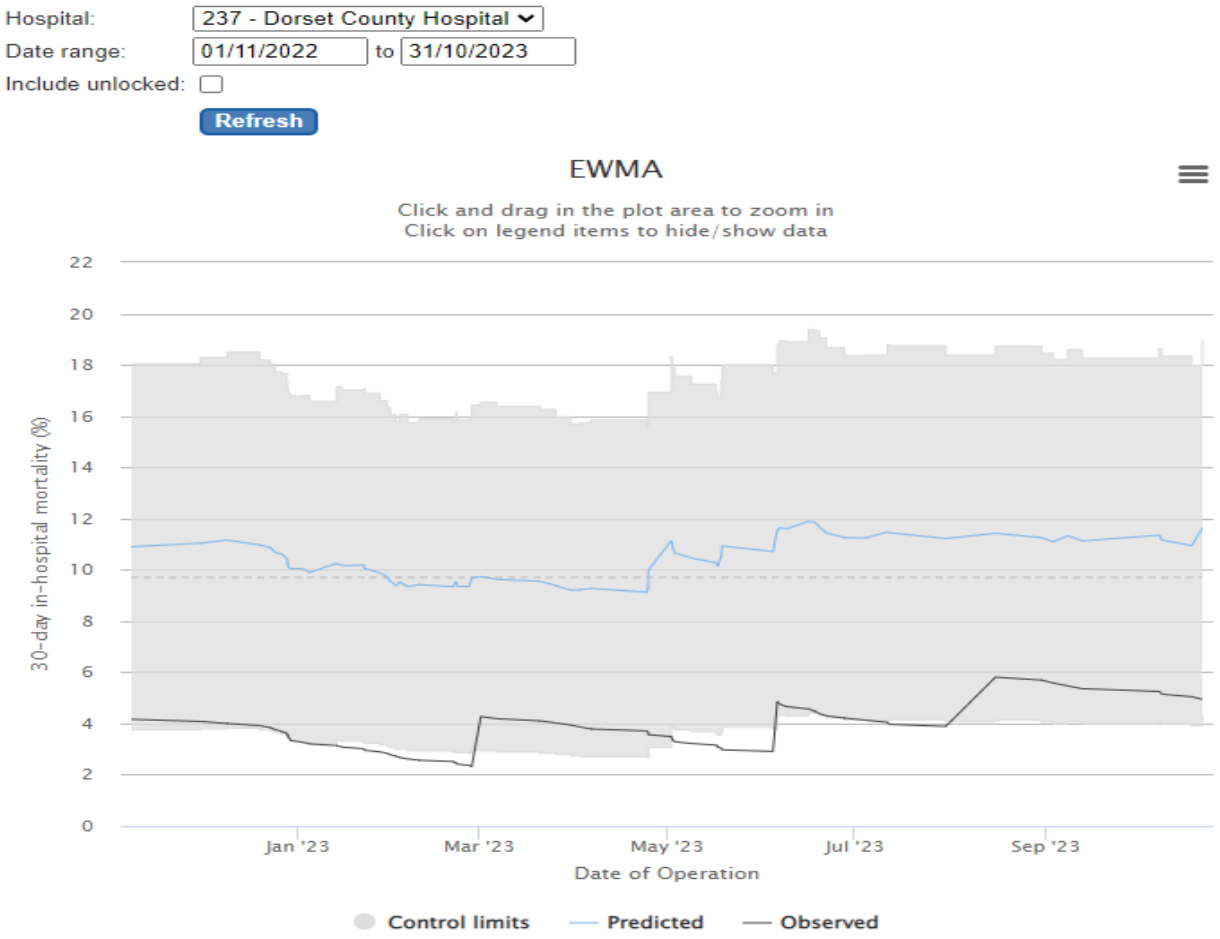
3.5 National Emergency Laparotomy Audit (no new data available at time of Q4 report)

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.



3.6 Getting it Right First Time; reviews in Qtr 4

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

Resp (TB) 22/03/24
Diabetes 01/05/24

Head and Neck Cancer scheduled 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 for the past 12 months as a result of a cyber attack and we are awaiting the recreation of the website.

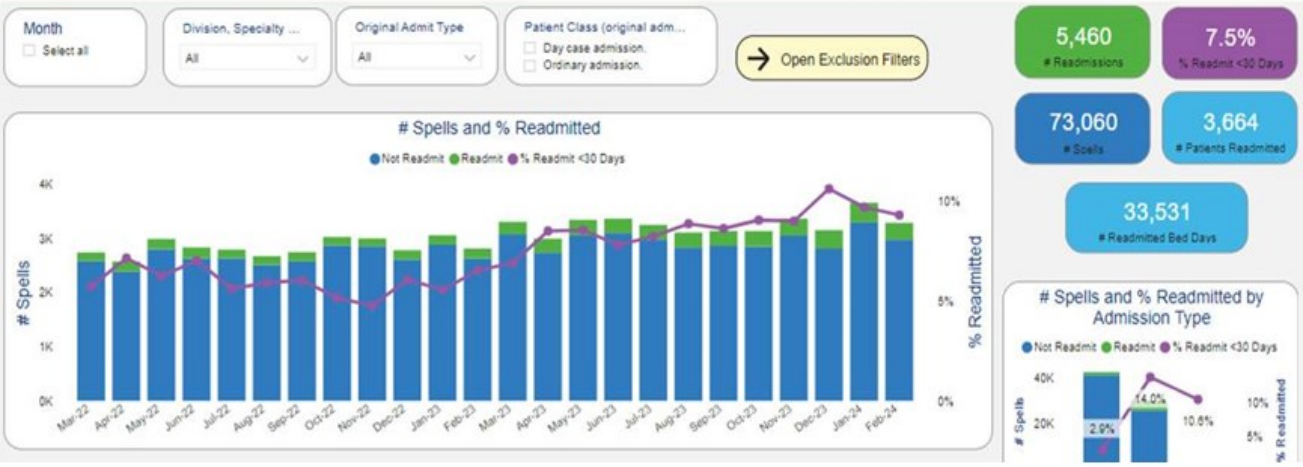
3.8 Readmission to hospital within 30 days

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.

Readmission rates have been going up, but not at the same rate as previously quoted.

The national dataset has exclusions for cancer and maternity which are now applied to the dashboard as filters. We have also filtered the data for planned re-admission to an emergency type area and also pathway changes, these included for example a patient that was admitted to EDAU then being admitted to the hospital, this resulted in a second admission. And also a patient who was seen and discharged to come back to SDEC. There were some other exclusions as part of the validation exercise. This gets us back to the chart below



There are still sustained increases in readmissions (which has increased by 70% over the study period) and therefore patient level analysis has been undertaken in order to better understand this. Readmission LoS has also increased significantly over this period, 10% of our bed base is currently being used by long LOS 1st and second admissions ie a patient staying for 21 days+ in first admission has a 28% chance of readmission within 30 days and then a very significant LoS in the second admission - this should be a focus of QI as they are easily identifiable and low numbers with a significant risk in terms of bed days. Regional variation with matched cohorts is another area of potential system QI.

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)

Local learning from child deaths (CDOP) mirrors national learning & has been summarised in a clinical audit report submitted by the designated doctor for child deaths for Dorset (July 2023):

https://dchftnhs.sharepoint.com/sites/ClinicalAudit/AuditReports/Forms/AllItems.aspx?id=%2Fsites%2FClinicalAudit%2FAuditReports%2F5060%20Child%20Mortality%20Database%20Audit%20Outcome%20Form%20%2Epdf&parent=%2Fsites%2FClinicalAudit%2FAuditReports

Key points:
63% of deaths that have been reviewed at a Child Death Overview Panel (CDOP) had modifiable factors identified (much higher than all deaths where modifiable factors are found in approx. 1/3). This suggests that many of these deaths are preventable.
Overall risk to children in the south west of England is relatively high at 18.84 / 1 000 000 children per year (national range 13.49 in the east of England to 21.17 in the north west).
Children with neurodiversity are disproportionately at risk. 11% of completed reviews for children aged 5-17yrs noted neurodiversity in the history while the population rates are reported as ASD 1.3% and ADHD 1.9%

Focus is on the following issues:

- *Knife crime (nationally) - Training in relation to medical management of penetrating wounds.*
  This is being led strategically by NHSE workforce training and education NHSE W/T/E) , ICBs, and major trauma ODNs for adults and children. DCH needs to ensure that we engage with this area of work and have appropriate training and updates for all staff involved in the care of major trauma patients.

- *Development of standardised bleed control and resuscitation training for young people.*
  Led by NHSE W/T/E, VRU and charities but clinical staff at DCH may be able to contribute to the training programmes being developed for young people as well as ensuring are workforce are up to date with these skills.

- *Prioritise measures to reduce the risk of Non-accidental injuries in infants.*
  This is an active area of work for the local SGP. Recent CSPRs have addressed these issues and identified learning. The NCMD report " The myth of invisible men" has been studied locally. Our maternity and primary care services work to identify families at risk and to be able to offer appropriate support to reduce that risk. The prebirth protocol for child protection has been updated. Fathers / step fathers are more included in prebirth assessments and offered support. ICON is promoted to highlight the risk of shaking infants.

- *Ensure safe bathing techniques are promoted.* Current advice about this need to be included in parenting information delivered antenatally and postnatally. This is relevant for maternity services and primary care.

- *Evidence based, age appropriate drug and alcohol education programmes for all children and young people aged 10-18 years.* Children admitted with drug / alcohol related conditions are assessed jointly with CAMHS and signposted to appropriate services.

- *Sudden unexpected death in infancy and childhood (SUDI / C) multiagency guidelines for care and investigation.* Local guidance has been updated. Support for peers of victims of suicide is provided including actions on the anniversary of deaths locally.

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)

MBRRACE have also published 2 reports comparing, respectively, the care of Asian and Black women with White women who have experienced a stillbirth or neonatal death. Published 14 December 2023. Last updated 11 January 2024

https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/confidential-enquiries/confidential-enquiry-asian.html

https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/confidential-enquiries/confidential-enquiry-black.html

3.10 National Perinatal Mortality Review tool

Data included in the Maternity safety report to Quality Committee

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) ***Learning from Divisional Quality Assurance Episode***:

1. Generally scoring similar but we all missed issues
2. Poor ICU clerking as patient admitted from theatre. Half clerked but not completed on arrival. This was discussed at ICU CGM. Highlighted issue and decision to handover to ICU team in recovery.
3. Documentation of consultant reviews and ward rounds poor at weekend. This has been discussed before but was covered again at the recent CGM

Outcomes:

1. If the death is being subject to a Coroner's case the team should do two SJRs to pick up issues that may have been missed with one.
2. Family complaints management reviewed
3. If score a 2 in overall care then for a second SJR prior to PSIRF consideration (we already do this)
4. Repeat this meeting on a regular basis – suggested 3-6 monthly

b) Optimising Medicines safety during transfer of care

Across the Dorset ICB learning from incident reporting and HMG supports a QIP to minimize harm from medicine related incidents. A project group has been established to improve medicines safety during transfer of care, focusing on medicines safety at the point of hospital discharge. The group have set a deadline for completion of stage 4 'implementing improvements' at 31st August 2024.

c) TEP DNAR Task group

Progress to support EoLC continues. A bespoke training package commissioned from Weldmar is being explored alongside in-house advanced communication skills training.
The policy update is nearing completion. Terminology changes from 'DNAR' to 'allow a natural death' are being considered within documents such as EDS to better facilitate conversations. Current methods of information sharing between hospital and community are being reviewed.

d) LeDeR

Adult with multiple comorbidities and neurodiversity died unexpectedly.
Care graded as falling short of expected good practice – this significantly impacted on the person's well-being and / or had the potential to contribute to the cause of death.

Rationale & learning:
Consideration of autonomy and whether communication practices met the person's needs in terms of supporting their decision making.
This highlights a gap in service provision to meet the needs of high-functioning neuro-diverse people, maybe beyond the scope of NHS services, but still to be considered when grading the care overall.

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.

Quality of clerking remains a recurring theme for improvement. Improving clerking, admission diagnosis and discharge summaries will also support clinical coding.

Examples of Learning and Actions from M&M Meetings:

Anaesthetics

1. Confirming correct patient arrives in anaesthetic room. Patient sent for, name and theatre number given, incorrect patient arrived, noted immediately and apologised to patient. Correct patient arrived but theatre list had a delayed start. Name had sounded similar. This was investigated and discussed with the member of staff at the time and asked to reflect on what happened. Discussed at dept governance to ensure correct full information is collected before releasing patients to theatres staff.
2. Patients with diabetes going first on list where appropriate – 2 datix cases. This has been disseminated to the Admissions Team and the SAL team have actioned as part of their preparations ensuring that Diabetic Patients are prioritised.
3. Some reversal ampoules in anaesthetic trolley were out of date. Half full box of vials in trolley, no in date ampoules in trolley. ODP asked to remove and replace. Reminded that ampoules should be checked at time of taking out of cupboard and at regular intervals. This has been shared with theatre team at governance and bi-weekly huddles.

Paediatrics

Cases discussed include :

1. Baby with changes on chest xray requiring intubation & ventilation (I&V)

   Learning reminder: Significant hypoxia & high FiO2 requirements are red flags for I&V.
2. Child with pre-existing GI condition presenting with abdominal distention and vomiting

   Learning reminder: Clinicians caring for child can challenge SORT advice as they can see the child.

   Parents of children with rare complex conditions can be expert in the condition that clinicians have not managed for a long time!
3. Ex premature baby with incarcerated hernia and dilated bowel loops

   Learning reminder: Surgical referral pathway does not include assurance if unable to contact team – feedback provided to UHS

Trauma & Orthopaedics

1. Fixation failure and infection after DHS 6 months prior

   Ultimately significant complication managed successfully

2. Intra-operative periprosthetic femoral fracture during revision TKR

- Complex surgical case, poor bone stock
- Discussed additional fixation and longer stems
- Patient doing well and happy with outcome

3. Failure of metalwork during DHS insertion

- Fatigue failure of DHS insertion jig
- All jig metal had to be painstakingly removed before redoing fixation
- Datix completed – awaiting feedback

4. Interprosthetic femoral fracture

- Multiple comorbidities
- Developed heart failure post-op, EoLCP, died three weeks post-op on ward
- Positives: Good MDT involvement throughout, swift definitive surgery, early recognition of palliative care
- Learning points: Difficult fluid balance due to comorbidities. Consider daily weights/ U+Es

Diabetes

- Earlier sampling required. Note – Vancomycin now kept on Ilchester for quicker access for patients. (staff to be made aware at team meeting).

Acute Medicine/ED

- Action: to work with diabetic team to provide education at Board rounds due to diabetic care becoming an emerging theme in risks.

6.0 LEARNING FROM CORONER'S INQUESTS Q4

DCH has been notified of 25 new Coroner's inquests being opened in the period 01 January 2024 – 31 March 2024. We have seen a huge increase in the volume and complexity of the cases.

7 inquests were held during Quarter 4. 6 inquests were heard as Documentary hearings, not requiring DCH attendance. 1 required the clinician to attend Court in person. 0 required attendance remotely using Microsoft Teams. The Risk Team no longer have a dedicated Virtual Court Room, due to office re-configuration. 2 pre-Inquest review hearings were held.

We currently have 54 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.

Learning Identified: Encourage clinicians to record any differential diagnosis.

National learning disseminated locally:
A recent ***'Prevention of Future Deaths Report'*** from the Berkshire Coroner highlighted the following:

- A patient with sepsis was discussed with the ICU team 'just to let you know'.
- The ICU team did not review the patient and they deteriorated and suffered a cardiac arrest and died later on that night.
- The report concluded: 'The need for training of all ICU clinicians at all levels ….that a 'just to let you know' call should result in an ICU review of the patient'.

This has been discussed in the DCH ICU CGM. This report has heralded the end of 'just to let you know'. These are now treated as formal referrals. The learning is taken into account when discussing patients with the ICU team.

7.0 LEARNING FROM CLAIMS Q4

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. The next GIRFT pack is due out in September, with the NHS Resolution due out in August.

Claims pattern Quarter 4 FY 23/24.

New potential claims	10
Disclosed patient records	30 (14 claims, 16 disclosures to the coroner)
Formal claims	5 clinical negligence, 1 employee claim
Settled claims	2 clinical negligence, 0 employee claims
Closed - no damages	2 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period December 2022 to December 2023.
The Trust's figure is 110.90, this is within the expected range using NHS England's control limits.
Of the ten groups for which NHS England publish SHMI values with control limits, eight have a SHMI value that is within the expected range. Septicaemia (except in labour) and Fluid and electrolyte disorders have a statistically significantly higher than expected SHMI.
Using Dr Foster 95% confidence interval, acute and unspecified renal failure is a relatively new alert and will be scrutinised in more detail at HMG.
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

continues to be 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.