Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, part 1	
Date of Meeting	10 December 2024	
Report Title	Learning from Deaths Q2 2024/25	
Prepared By	Dr Julie Doherty / Prof Alastair Hutchison	
Approved by Accountable Executive	Prof Alastair Hutchison, Chief Medical Officer	
Previously Considered By	Hospital Mortality Group, 13 Nov 2024 Quality Committee 26 Nov 2024	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	Potential implication if coding needs additional resources (to improve staff recruitment & retention)	
Statutory & Regulatory	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. 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.	
Equality, Diversity & Inclusion	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	
Co-production & Partnership	Potential implication if further joint working with DHC to support coders.	

Executive Summary

The purpose of the report is 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.

- The latest published SHMI data (5 months in arrears) for DCH was 1.1023 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. There has been a recent decrease in depth of coding which is concerning.
- There is an increasing backlog of SJRs awaiting completion in Division A. A plan is being drawn up to mitigate risk & to try to address the issue.

Recommendation
Members are requested to: • **Approve** publication of the report.

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 2024/25 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 45 deaths in quarter 2, of which 40 that require SJR's to be completed. Within quarter 2 39 SJR's have been completed from this quarter and previous months.

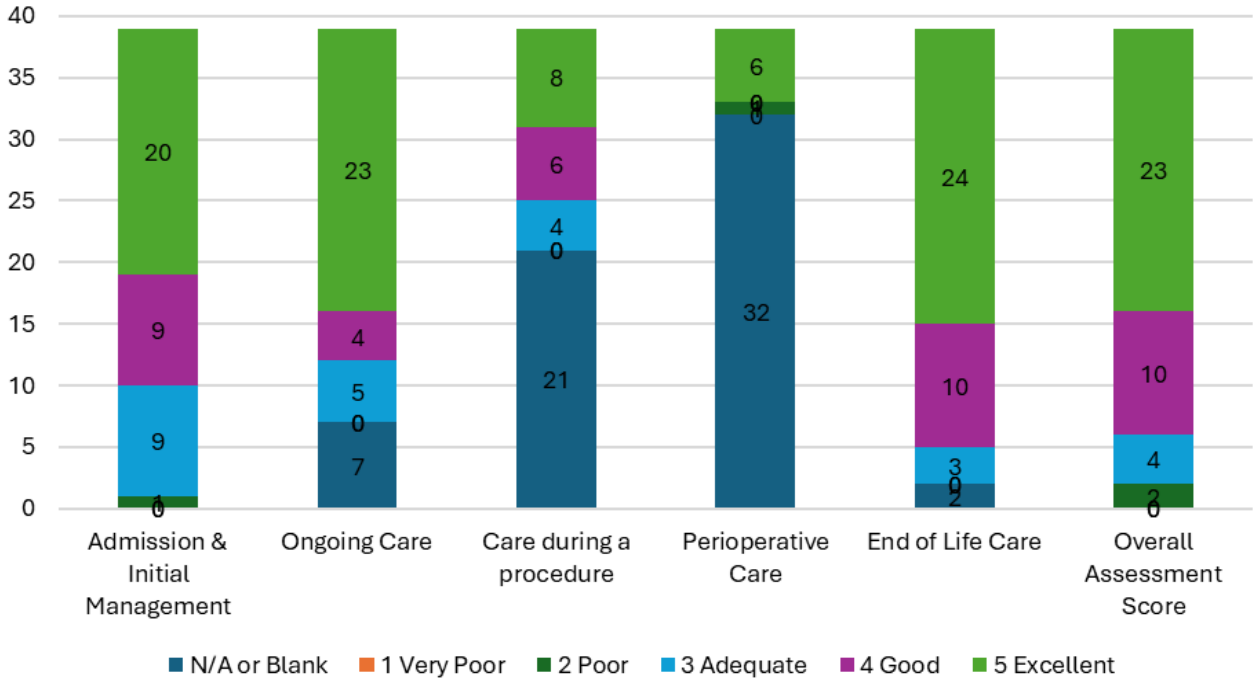
Outstanding SJR's:

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 31/10/2024 is 24:

May	June	July	August
3	6	7	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	7	21	32	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	0	1	0	2
3 Adequate	9	5	4	0	3	4
4 Good	9	4	6	0	10	10
5 Excellent	20	23	8	6	24	23



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	8	13	18

- Difficult to navigate the care provided in ED due to the Agyle system used there, otherwise record of events, treatments provided, MDT involvement, family conversations all documented clearly and concisely.

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	1	0	2	36

Action Required:

Following completion of the 39 SJR's, 8 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.

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings.

- 3 requested second SJR from specific specialty.
- 1 was for discussion at Quality Assurance meeting.

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.

Learning from Division

1. Earlier NGT if patients can't swallow
2. Benefits of early chlordiazepoxide in alcohol withdrawal
3. If paraplegic and unwell with PUO – consider early CT
4. Need to document functional status on admission

Emerging Themes:

1. Excellent family communication
2. Long ED stays for severely unwell patients -Trustwide awareness and risk mitigation in progress
3. Difficulties in accessing Hospice Care – raising awareness of availability of palliative care team and palliative care suites in Community hospitals.
4. Continued instances of poor surgical clerking - repeat audit conducted and action plan in place
5. Increased use of bedside echo in ICU to guide treatment

1.2 Division of Urgent & Integrated Care – Quarter 2 Report 2024 / 25

In quarter 2 there were 262 deaths (**80% rise to Q1**), 54 SJR's were requested **(69% rise to Q1)** from these deaths, and 12 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q2			Q3			Q4			Q1			Q2		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Deaths	65	58	60	49	41	63	65	59	69	48	52	45	75	105	82
Deaths requiring SJR'S from Month	15	14	18	11	14	13	15	16	12	9	8	15	6	22	26
*Completed SJR'S	2	14	17	20	12	3	7	11	2	6	10	9	1	9	2

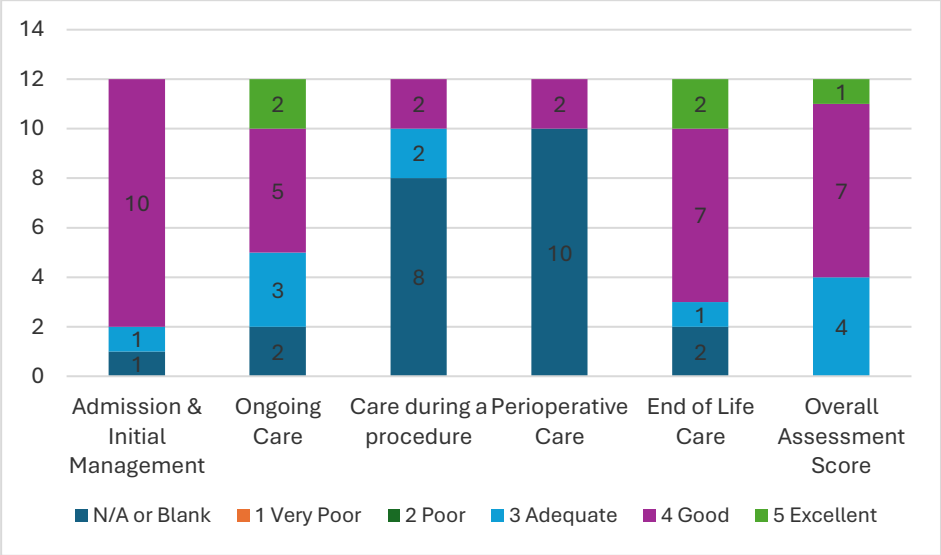
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 12/11/2024 is 119 including outstanding nosocomial reviews:

Jul	Sept	Oct	Nov	Dec	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1	5	7	4	6	7	15	8	7	8	0	5	20	26

Phase score from 12 completed SJR's 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	1	2	8	10	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	1	3	2	0	1	4
4 Good	10	5	2	2	7	7
5 Excellent	0	2	0	0	2	1



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	1	9	0

- Noted that some records are difficult to read and not in time order

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	1	11

Action Required:

Following completion of the 12 SJR's, 0 required further actions:

SJR Key themes from Areas of Good Practice:

- Early Involvement and recognition of palliative care and discussions with family
- Good and prompt review by MDT

SJR Key theme of Areas for Improvement:

- On-site face to face palliative care team representation at a weekend – may be gaps in provision
- More prompt initial consultant assessment on admission
- Completion of nursing documentation
- Sepsis diagnosis earlier identified and documented
- Complete documentation of DNACPR

Areas for escalation

Number of SJRs being received is increasing and current process does not facilitate capacity to complete all of these and tackle the backlog the division currently hold (95). There is currently no identified formal training for staff members keen to start completing SJR's. System that facilitates completion of reviews is not user friendly.

Process for identifying & sharing learning from M&M requires improvement.

Initial plans to mitigate risk:

- Review triggers for SJR (original target set nationally was for ~20% of deaths to be reviewed via SJR; DCH numbers consistently above this)
- Formal training required to widen the pool of who can complete SJR's. RJ looking into provision.
- Process for sharing learning under review by divisional directors.

For further LfD and QIP see section 4.

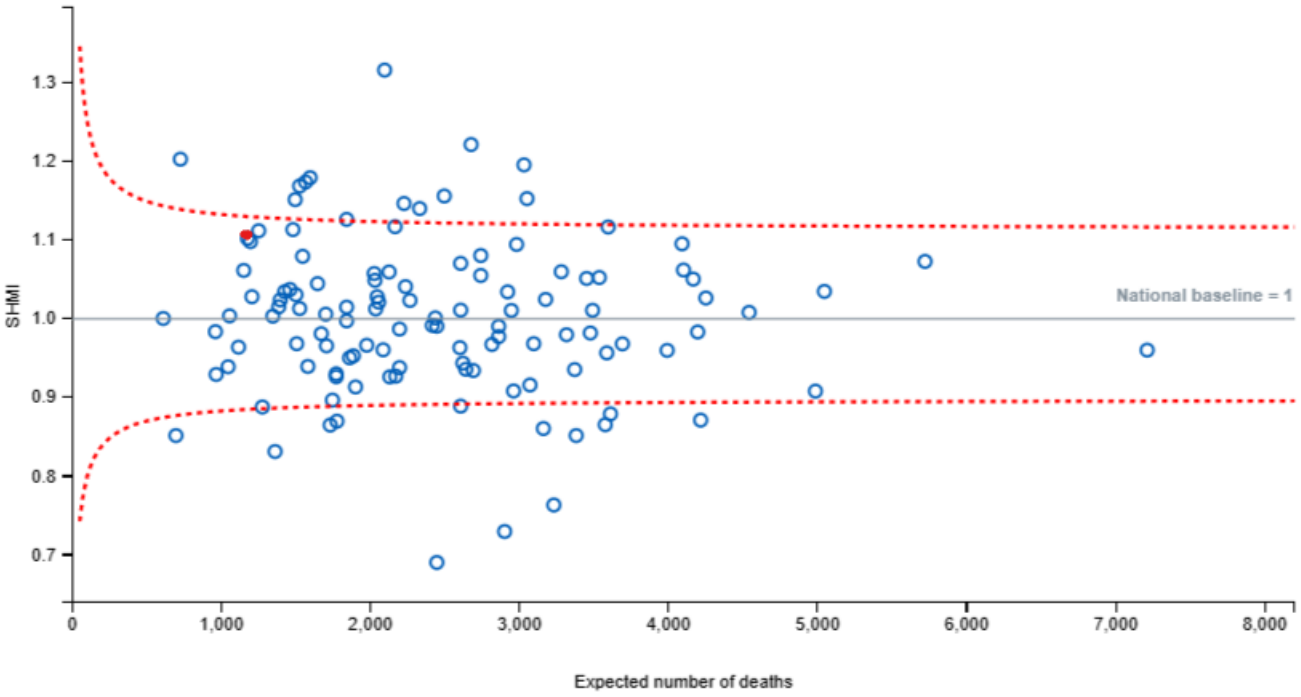
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

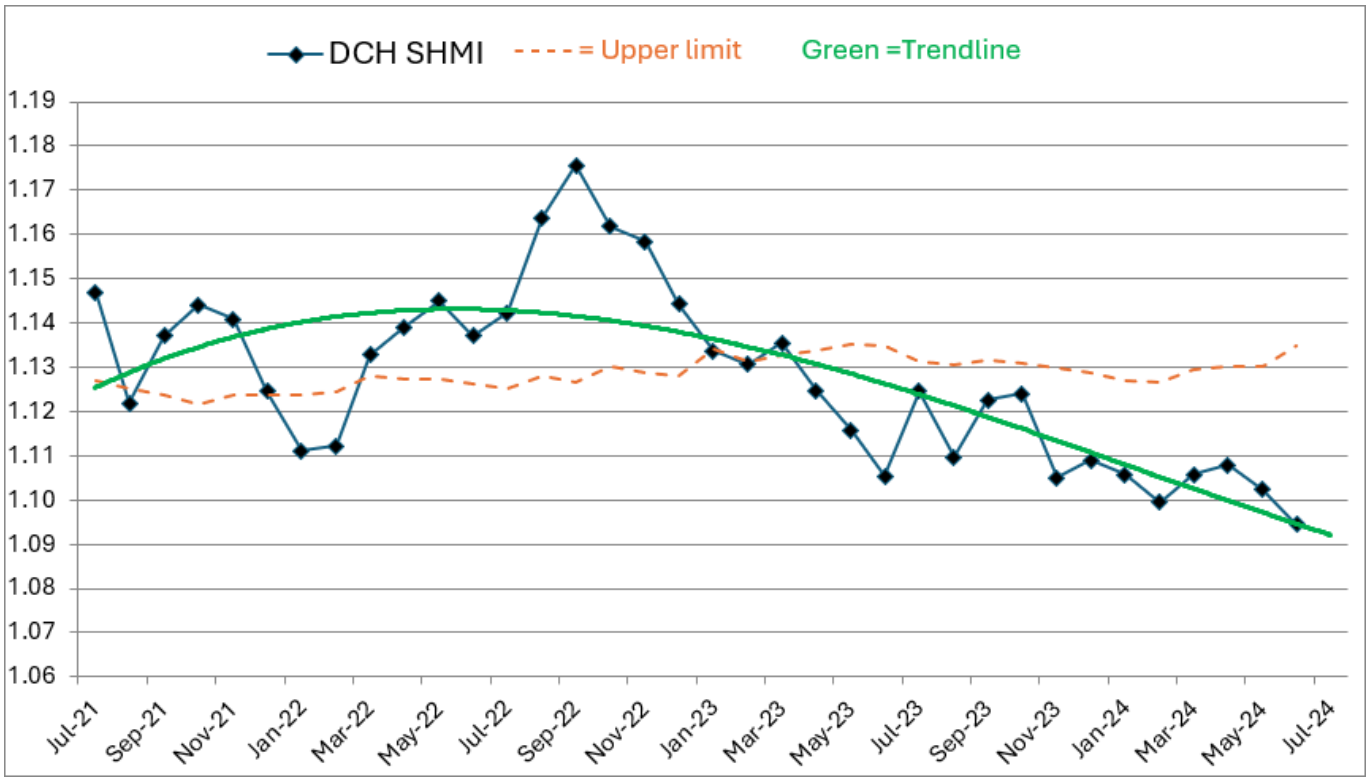
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

The latest SHMI publication from NHS England is for the period June 23- May 24. **The Trust's figure is 1.1023. which is within the expected range** using NHS England's control limits.

DCH =red dot



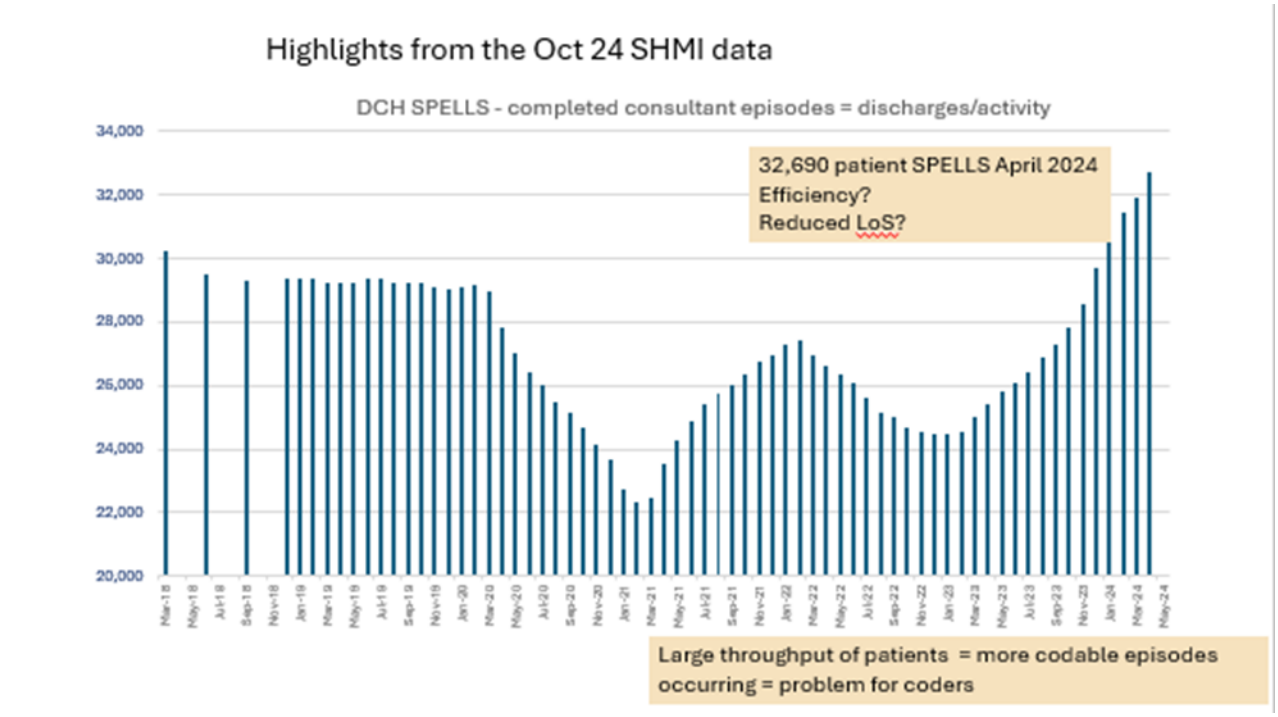
We are aware that our data is influenced by staffing levels in the Coding Department (though mitigations in place), and a possible under-reporting of 'sepsis' in the medical record.
Septicaemia is a recurring alert and further exploration of this is being undertaken (with support from the Deteriorating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

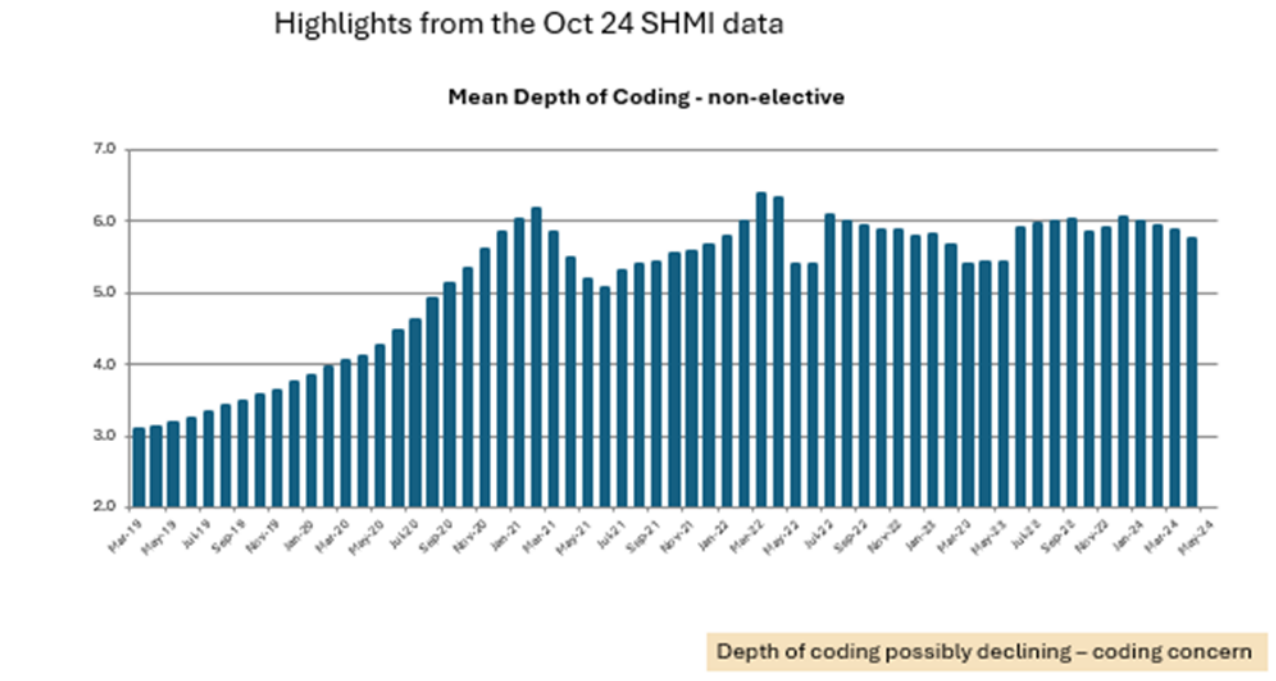


2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 stabilised at around 6.0 – in line with the national average (5.9) for non-elective admissions, somewhat concerningly however it has reduced again to just below this figure at 5.8. Dorset Healthcare have been able to provide an additional 20 hours/week of coding time which helps significantly but there remain concerns regarding lack of resources available to coding. DCHFT mean depth of coding for elective admissions is now further below the England Average at 5.2(compared to 6.1).

DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.7 (England average 13.8).

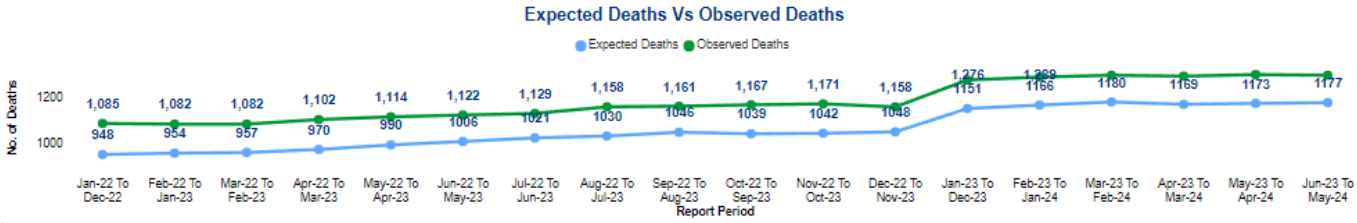


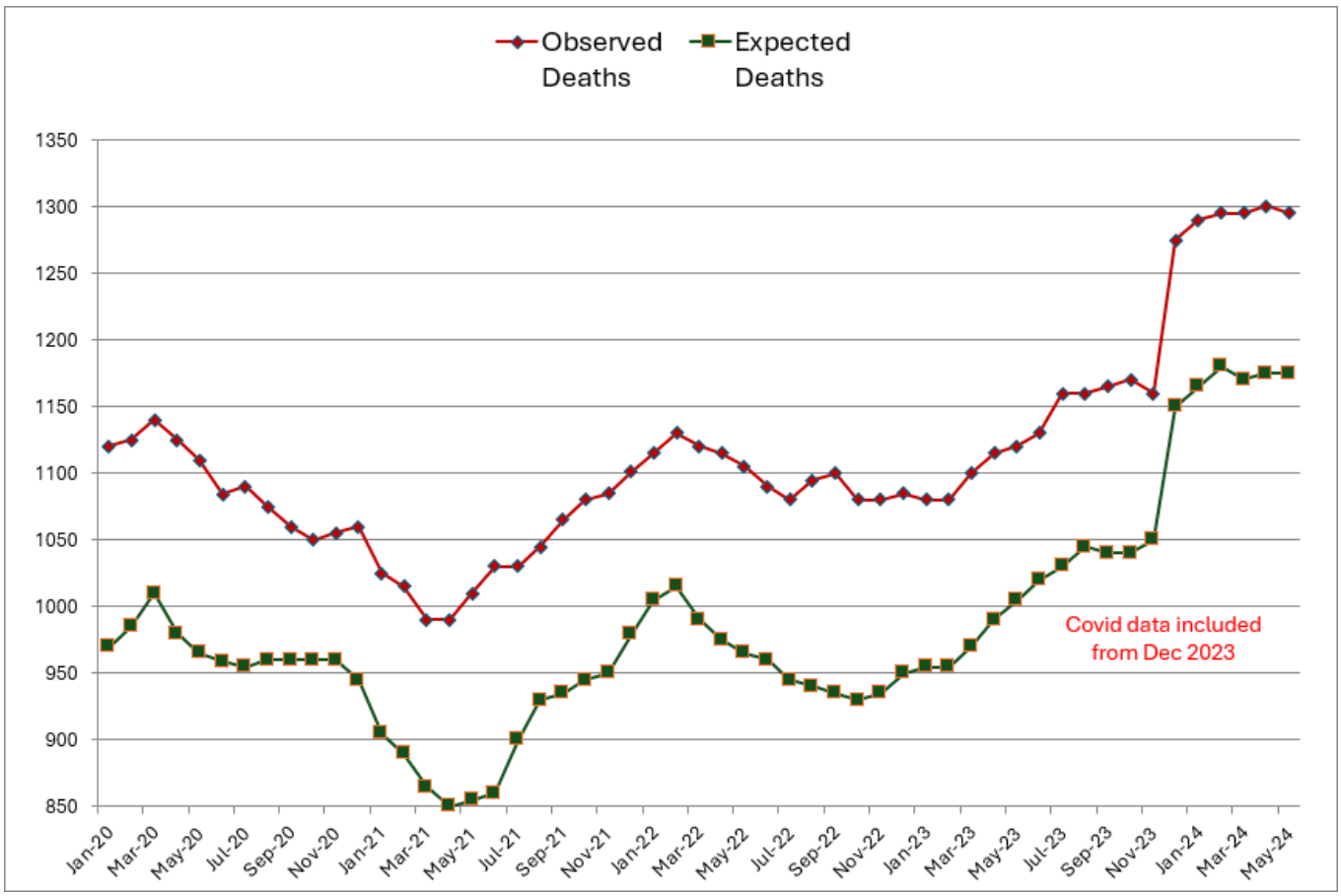


2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths, 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 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.

The observed deaths for this quarter are 1295 with expected deaths at 1175 from 32690 provider spells.





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.

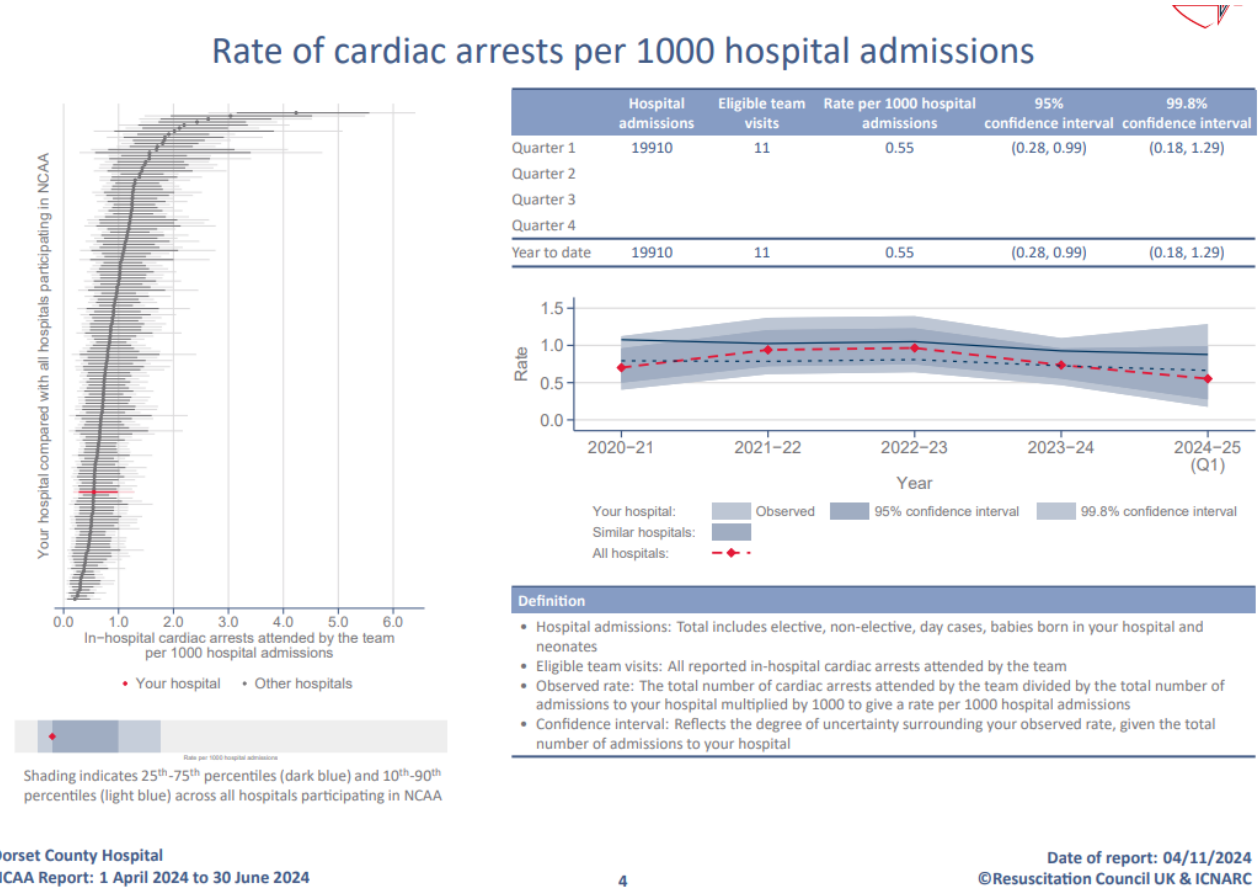
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

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

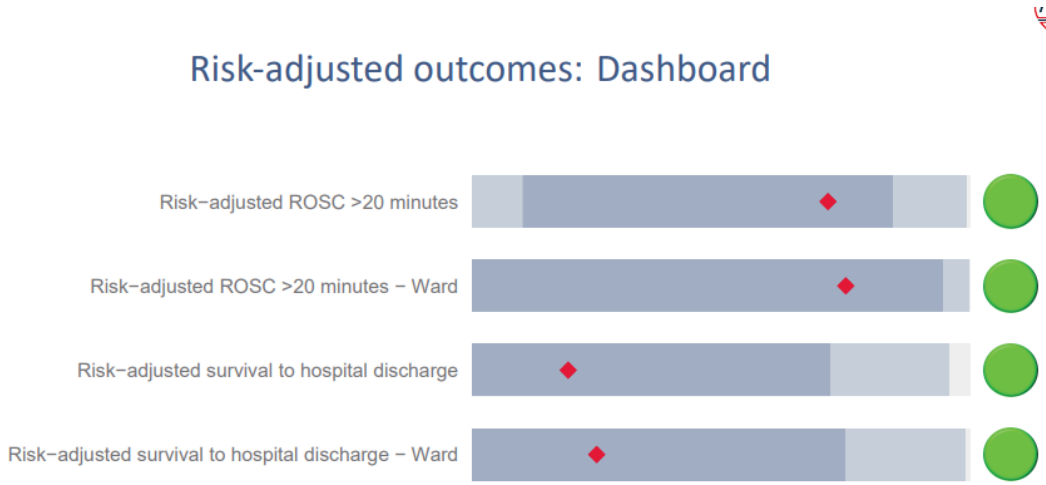
The latest national Cardiac Arrest audit for DCH includes data from 1 April 2024 to 30 June 2024 & was published on 04/11/24. Frequent cardiac arrest calls suggest unanticipated deteriorations in a patient's condition, whereas fewer calls suggest higher standards of ward care, although this is unproven.

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:

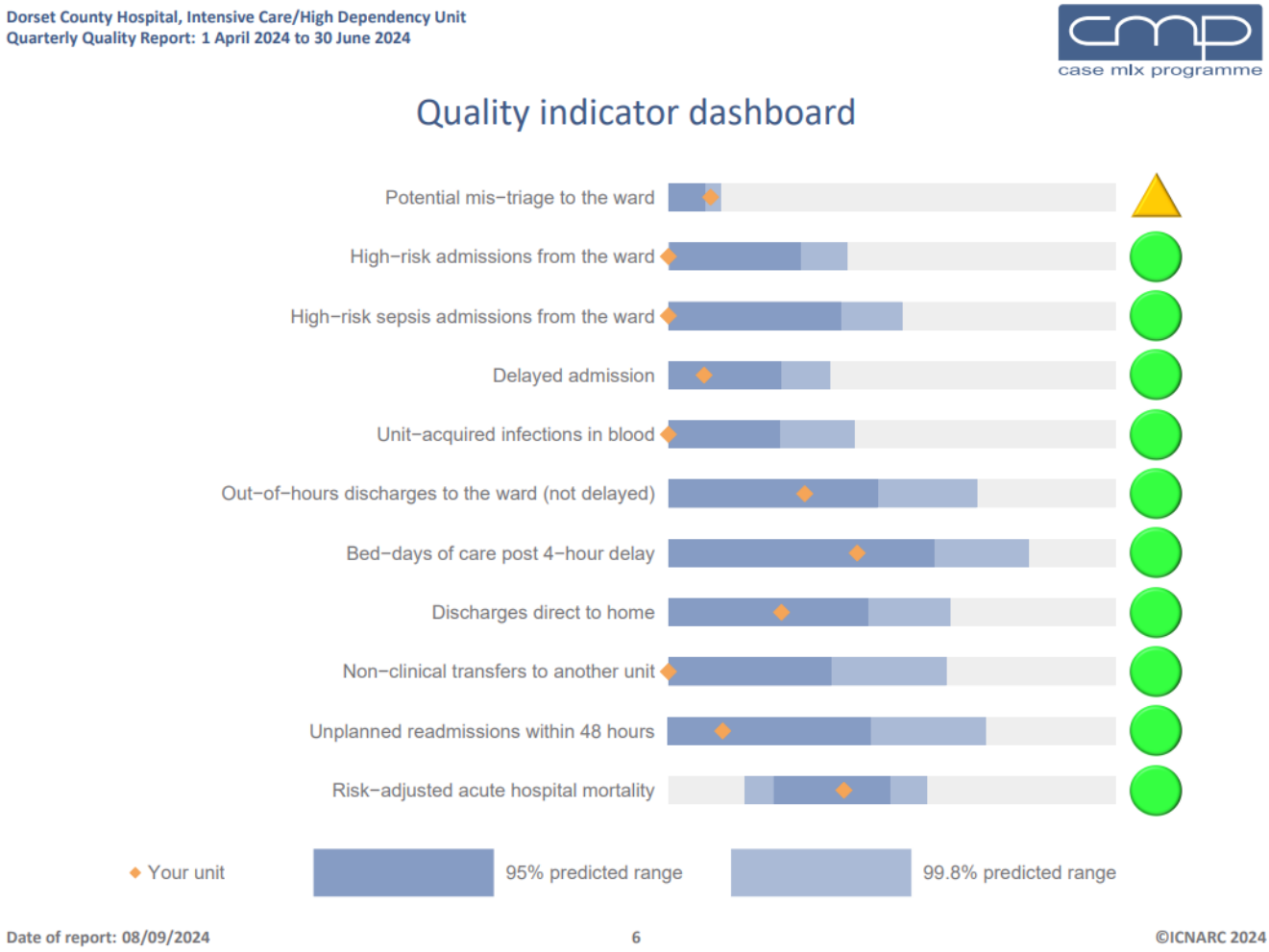
a) Time to 'Return of Spontaneous Circulation' (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator.



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 Q1 dates 1 April 24 - 30 June 24 published Sept 2024 and based on 175 admissions of 168 patients.

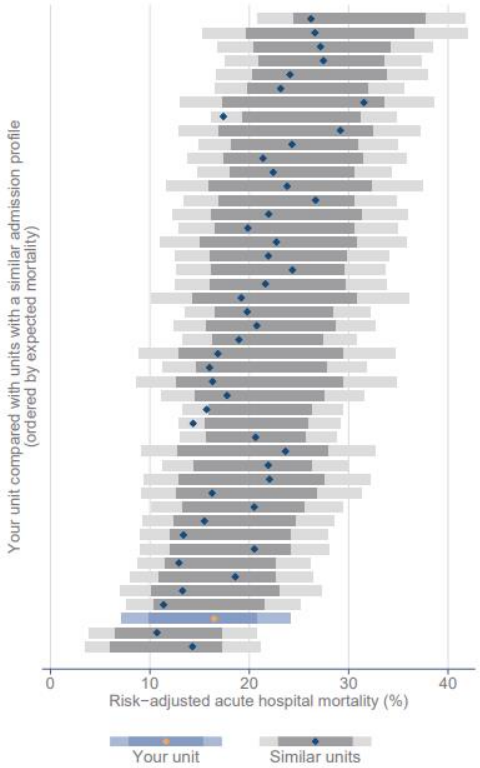
All but 1 of the indicators remain in the GREEN area. Potential mis-triage to ward has previously been 'green', thus awaiting results for next quarterly publication.



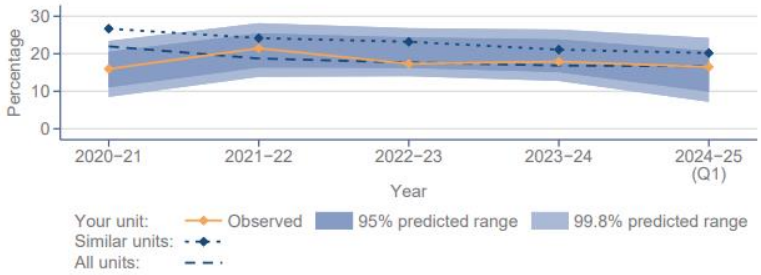
The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.

These results are well within the expected range.

Risk-adjusted acute hospital mortality



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	170	170 (100.0)	●	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	●
Quarter 2								
Quarter 3								
Quarter 4								
Year to date	170	170 (100.0)	●	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	●

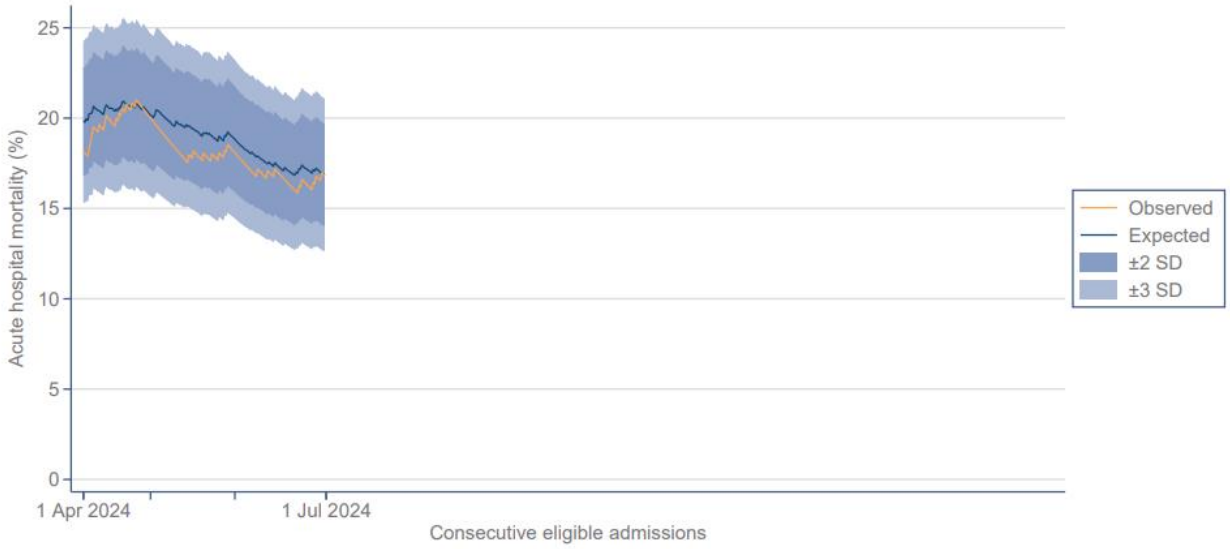


Your unit: Observed 95% predicted range 99.8% predicted range
Similar units:
All units:

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

Risk-adjusted acute hospital mortality (EWMA plot)

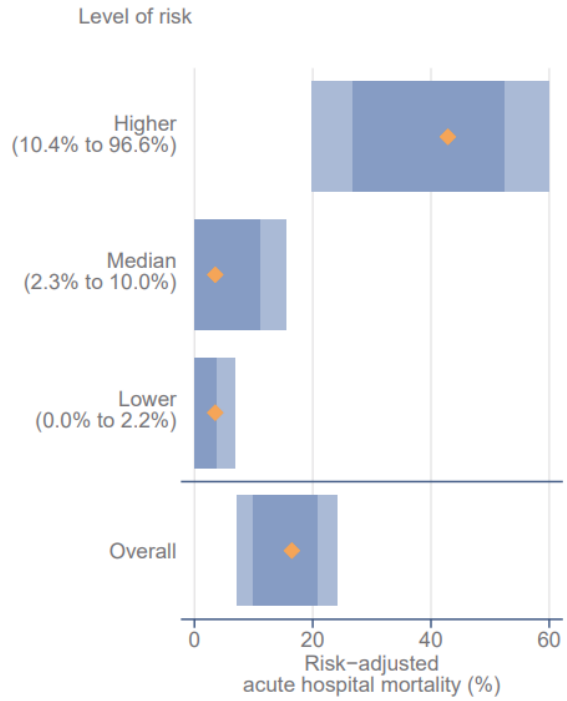


Explanation

- 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)

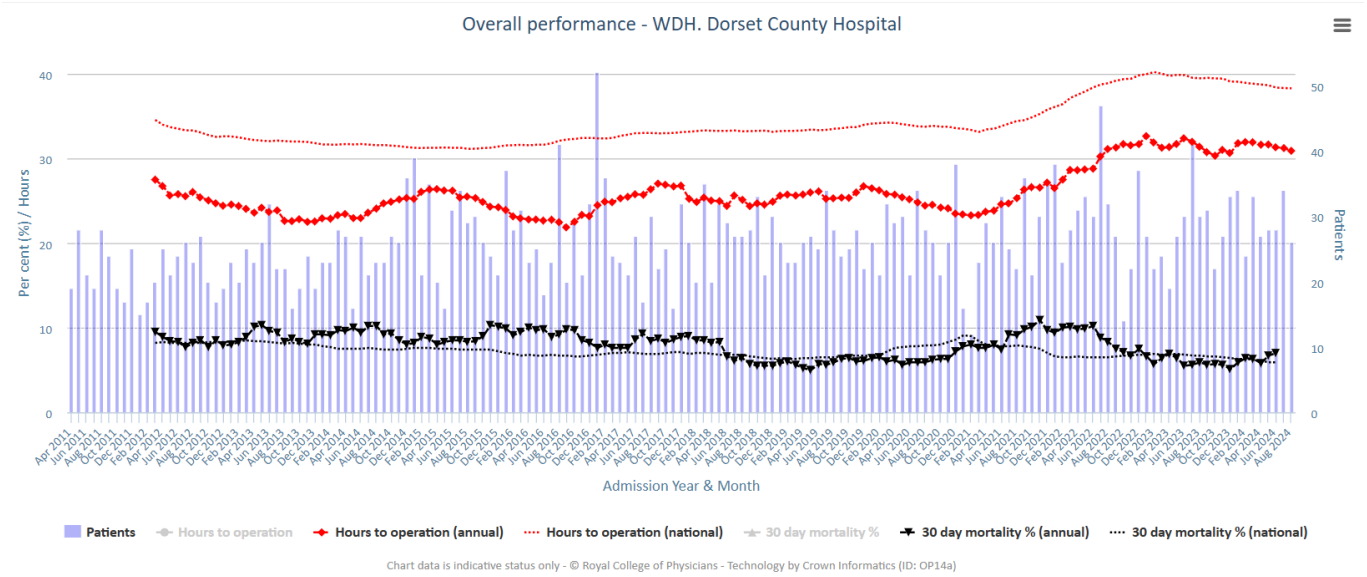


Level of risk	N	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Higher	56	24 (42.9)	40.2	(26.7, 52.4)	(19.8, 60.0)	
Median	57	2 (3.5)	5.3	(0.0, 11.0)	(0.0, 15.6)	
Lower	57	2 (3.5)	1.1	(0.0, 3.7)	(0.0, 6.8)	
Overall	170	28 (16.5)	15.4	(9.9, 20.7)	(7.2, 24.2)	

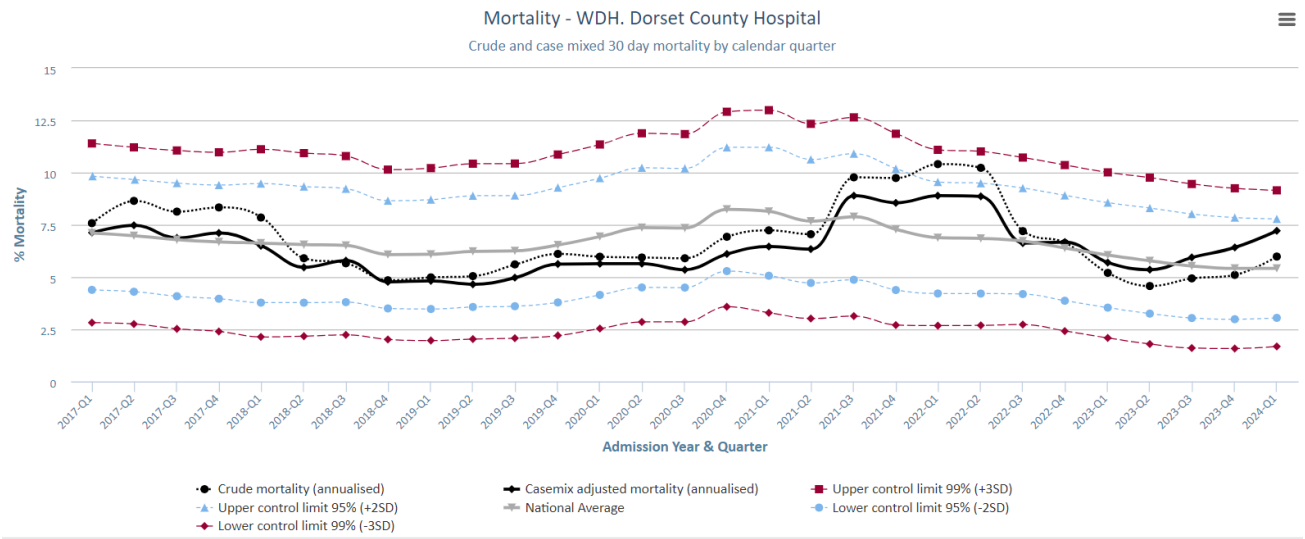
Explanation

- 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

3.4 National Hip Fracture database



'Hours to operation' remains significantly better than the national average with 30 day mortality in line with the national average. The trauma lead and trauma coordinators are looking into the mortality data which is now plotting just above the national average. Data quality was an issue the last time this occurred but we are obviously keen to understand the trend better.



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.

3.6 Getting it Right First Time

Since the last LfD report, the following reviews have been conducted via GIRFT / external organisations:

07/08/2024	Acute Oncology Service Review	Wessex Cancer Alliance	cancer services
09/08/2024	Pharmacy Aseptic Unit Audit	Regional Quality Assurance South West	Pharmacy
Sep			
02/09/2024	Histopathology ISO 15189:2022 transition (project 317497)	UKAS	Histopathology and NG cytology
17/09/2024	General Surgery Gateway Review - Dorset ICS	GIRFT	Gen Surg
27/09/24	Endocrinology (Medicine & Surgery) Gateway Review SW Region	GIRFT	Endocrinology

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.

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)

No new releases Q2.

Paediatric Mortality for Q2:

There have been 2 child deaths in Q2; 1 expected and 1 unexpected.

The notification pathway following an unexpected child death has been updated to ensure practice consistency and timely information sharing.

Pan Dorset & Somerset CDOP continues to review cases and share learning as appropriate. CDOP is planning a learning event in March 2025 for professionals from all agencies.

3.10 **MBRRACE** data:

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU

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/

No new reports / data for Q2

3.11 National Perinatal Mortality Review tool

Reports | PMRT | NPEU

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

There has been a total of 4 perinatal deaths occurring at DCH reported via the PMRT in Quarter 2. None of the cases met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).

No concerns have been raised with the notification and surveillance submissions and the current reporting process is to continue.

To improve local learning all perinatal deaths reported by other tertiary centres, involving mothers who receive their antenatal care pathway with DCH as primary care givers will be included.

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. Management of backlog of SJR in Division A
2. Mortality Review policy update complete

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:

Orthopaedic

1. Infection left THR
   - Early aspiration and aggressive debridement
   - Good MDT liaison
   - Infection resolved

2. Wound infection left long gamma nail
   - Early senior review and debridement
   - Infection resolved and fracture union without removal of nail

3. Failure of ankle ORIF metalwork
   - Failure to recognise latent malleolus displacement
   - Registrar supervision in clinic

4. Patient transferred from medics to ortho without notification
   - Admitted under medics with intracranial bleed, considered to be potentially traumatic
   - Transferred to ortho ward without senior notification
   - Deterioration clinically soon after transfer
   - Agreed in future to remain under medics if medical issues outweigh ortho issues

Paediatrics

Learning & actions:

- Discussions around risk to self vs patient care: At what point does risk to staff override treating patient? Actions to be taken / considered if a staff member refuses to be involved in a situation due to concerns about their own safety?
- Support for junior staff to contact the most senior people on call if they have patient and/or staff safety concerns?
- Recognition of when post-ictal becomes unconscious / reduced GCS not caused by the seizure?
- Excellent ITU support & good escalation of care within teams (PIMS – TS)

Anaesthetics

1. Checking & documentation of important family history in pre-assessment. A separate elective section list and greater anaesthetic staffing e.g. in the afternoon in obstetrics may take the pressure off the busy environment and reduce missing important clinical information.
2. Patients should not leave recovery area in pain – appropriate drug rescue should be prescribed and given if needed in recovery.
3. Premedication issues: staffing issues + checking whether the premed has been given so intra-op medications can be adjusted if necessary.
4. RIH repair listed as LIH – appropriately marked and consented. Learning: WHO check picked this up appropriately prior to anaesthesia – good use of checklist.

5. Standard practice in dental surgery is to remove cannula before patient leaves – some of anaesthetic team not aware of this, risk put in as anaesthetist asked for a cannula to remain in a patient – unclear whether appropriate or not but note guidelines are such and can be deviated from when appropriate.
6. Out of date drugs – boxes of muscle relaxants found to be out of date so ensure drug ampoules always checked.
7. Latex allergy noted at sign in – not discussed in team brief so delayed the list but good use of WHO check list picking this up. Ensure allergies discussed in team brief, consider latex free hospital.
8. Transfusion traceability tag for platelet unit not returned. All anaesthetists should do blood transfusion training. Ensure tags returned.
9. Awareness of hazard's next to theatre table.

General and Colorectal Surgery

1. Good care of patient with sepsis.
2. Complex surgical history & elective surgery for colon cancer. Post op sepsis, not drainable with IR. Complex case with a long post op stay. Abdo collections effectively managed with open drainage.

Elderly Care & Stroke

- Setting up refresher education session and feedback for SpRs
- Monthly update email to be set up
- SpR document being created around stroke on calls to support building confidence

6.0 LEARNING FROM CORONER'S INQUESTS Q2

During the period 01.07.2024 to 30.09.2024, 22 inquests were opened. A total of 11 Inquests Hearing were held in this period.

For these 11 cases, 16 statements were obtained from clinicians involved in the patient's care.

Of the 16 statements provided, only 3 clinicians were called to give live evidence..

No Inquests have progressed to a claim in this period as yet.

52 open inquests.

No legal representation was required to support the Inquest process through this period and 1 Pre-Inquest Review (PIR) was conducted. This PIR will result in a Jury inquest next year.

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

Learning Identified:

- Lack of Care Plan from Care Home, should have been requested on admission to DCH
- Delay in hydration on admission

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 24/25.

New potential claims	14
Disclosed patient records	15
Formal claims	4 clinical negligence 1 employee claim
Settled claims	0
Closed - no damages	12 (limitation expired)

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 May 2023 – 30 June 2024. The Trust's figure is 1.1023, 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.

Work planned to agree an action plan to support completion of SJR within division A.

MORECOMBE BAY PROGRESS UPDATE- OCTOBER 2024

- Review frequency of RO reporting to Board – complete and for further consideration with appointment of Interim CMO
- Consider developing an 'Employer Relations Report'
  - Analysis of no / type grievances & disciplinaries via care group
  - No of clinical performance improvement plans
  - +/- bullying / harassment; whistleblowing and FTSUG report
- Establish Decision Making Group (DMG)- Draft Terms of Reference created and first meeting planned. Aim to make this Multi-disciplinary across Medical, Nursing and AHPs.
- Audit of Case investigation & management with regard equality & diversity– undertaken previously for Nursing; underway for Medical.
- Strengthening clinical audit– link to claims / complaints - Deputy Director of Nursing 'Heads of' meeting established to triangulate; Quality Surveillance Group to be re-established

  Triangulating the learning from and handling of complaints, incidents and claims
- Strengthening mortality reviews and Board reporting – included in Clinical Governance review; Neonatal, Paediatric and LeDeR data to be included in Hospital Mortality Group and Learning from Deaths Report.