Dorset County Hospital
NHS Foundation Trust

| | | |
|---|---|---|
| **Report to** | DCH Board of Directors | |
| **Date of Meeting** | 08 April 2025 | |
| **Report Title** | Learning from Deaths Q3 2024/25 | |
| **Prepared By** | Dr Julie Doherty / Prof Alastair Hutchison | |
| **Approved by Accountable Executive** | Dr Rachel Wharton | |
| **Previously Considered By** | Hospital Mortality Group, 05 March 2025<br>Quality Governance Group 12 March 2025<br>Quality Committee 25 March 2025 | |
| **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** | Please complete all boxes in this section. If there is no implication, please state 'no implication'. | |
| **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.<br>An elevated SHMI will raise concerns with NHS E&I and the CQC.<br>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** | Please complete all boxes in this section. If there is no implication, please state 'no implication'. | |

## Executive Summary

The purpose of the report is to inform the Board 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 1.043 This is within the expected range. SHMI data is showing a decreasing trend at DCHFT with the most recent result the best figure for many years.
- Despite the reassuring SHMI trend and latest figure we are not complacent. We continue to review our depth of coding in case we notice that SHMI is being 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 but this now appears stable and not further reducing.

- The backlog of SJRs awaiting completion in Division A is in the process of being addressed.

**Recommendation**

Board are requested to:

- Receive the report for **approval**

## 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 3 2024/25 Report

**Structured Judgement Review Results:**

The Family Services & Surgery Division had 57 deaths in quarter 3, of which 52 that require SJR's to be completed. Within quarter 3 58 SJR's have been completed from this quarter and previous months. The division reports having sufficient numbers of reviewers and that SJR backlog relates mainly to the delay in receiving deceased records (DPR is not appropriate for conducting SJRs).

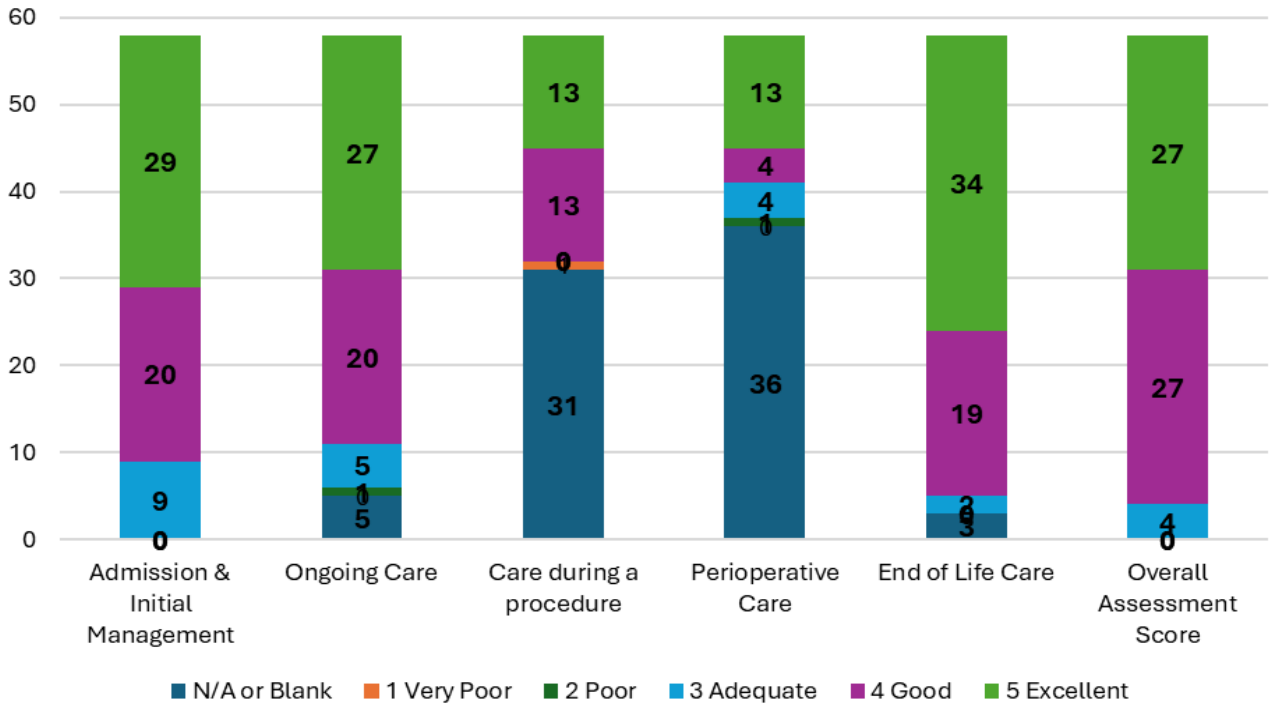
**Outstanding SJR's:**

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 09/02/2025 is 12:

| October | November | December |
|---|---|---|
| 4 | 2 | 6 |

**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 | 5 | 31 | 36 | 3 | 0 |
| **1 Very Poor** | 0 | 0 | 1 | 0 | 0 | 0 |
| **2 Poor** | 0 | 1 | 0 | 1 | 0 | 0 |
| **3 Adequate** | 9 | 5 | 0 | 4 | 2 | 4 |
| **4 Good** | 20 | 20 | 13 | 4 | 19 | 27 |
| **5 Excellent** | 29 | 27 | 13 | 13 | 34 | 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 | 2 | 5 | 23 | 28 |

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 | 7 | 51 |

## Action Required:

Following completion of the 58 SJR's, 4 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 – completed.

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. Delay in PICC line due to no vascular access service. No TPN for 5 days. Affecting patient care. Business case to be reviewed and escalated to Clinical Effectiveness Committee.
2. Continued poor surgical clerking with omissions in PMH, Meds and cardiovascular / respiratory examination. Divisional director with clinical lead(s) meeting to discuss efforts for quality improvement.
3. Need to fill out TEP if DNAR. Presentation of TEP Policy to clinical leads group and consider further communication methods to relevant medical staff.
4. High Quality ED documentation

## 1.2 Division of Urgent & Integrated Care – Quarter 3 Report 2024 / 25

In quarter 4 there were 177 deaths, 51 SJR's were requested from these deaths, and 5 SJR's were completed during this period (completed SJR's not necessarily from this quarter). The division is in the process of review and establishing a new system for SJR review.

| | Q3 | | | Q4 | | | Q1 | | | Q2 | | | Q3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Oct | Nov | Oct | Jan-24 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Deaths | 49 | 41 | 49 | 41 | 49 | 41 | 48 | 52 | 45 | 75 | 105 | 82 | 59 | 65 | 53 |
| Deaths requiring SJR'S from Month | 11 | 14 | 11 | 14 | 11 | 14 | 9 | 8 | 15 | 6 | 22 | 26 | 14 | 12 | 15 |
| *Completed SJR'S | 20 | 12 | 20 | 12 | 20 | 12 | 6 | 10 | 9 | 1 | 9 | 2 | 4 | 0 | 1 |

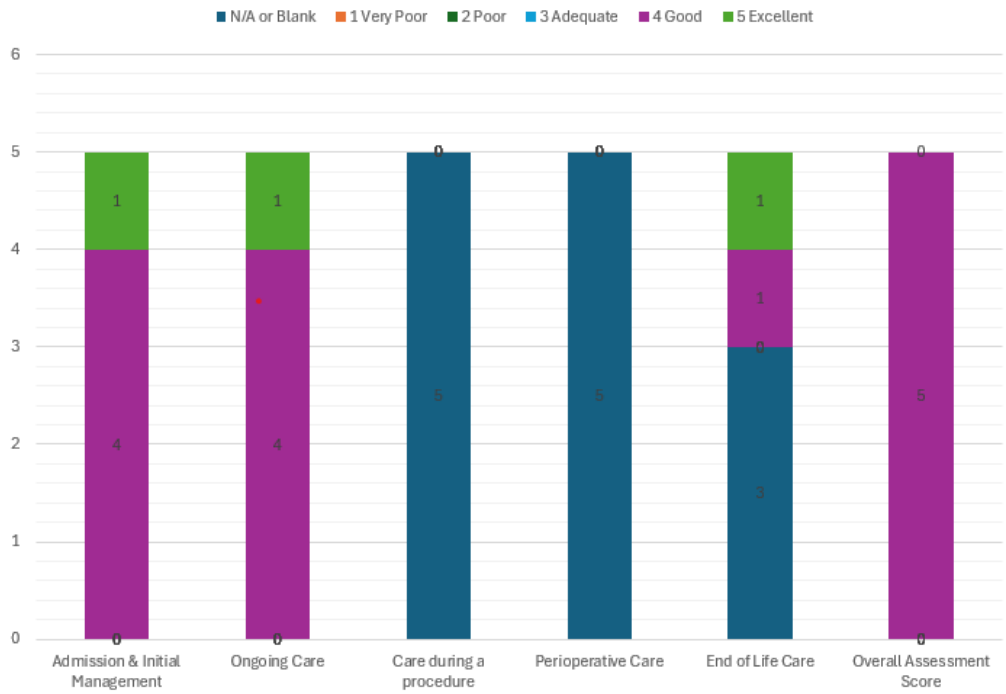
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division for Q3

| October | November | December |
|---|---|---|
| 10 | 12 | 14 |

**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** | 0 | 0 | 5 | 5 | 3 | 0 |
| **1 Very Poor** | 0 | 0 | 0 | 0 | 0 | 0 |
| **2 Poor** | 0 | 0 | 0 | 0 | 0 | 0 |
| **3 Adequate** | 0 | 0 | 0 | 0 | 0 | 0 |
| **4 Good** | 4 | 4 | 0 | 0 | 1 | 5 |
| **5 Excellent** | 1 | 1 | 0 | 0 | 1 | 0 |




## 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 | 0 | 5 | 0 |

- Good record except ED agyle notes
- Clear handwriting, dated and signed entries bar one.
- Very detailed, all notes appear to be present.
- Good documentation on Agyle. Clear plan from medical team.

## 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 | 0 | 5 |

## Action Required:

Following completion of the 5 SJR's, 0 required further action as they were all scored as 'definitely not avoidable'.

## SJR Key themes from Areas of Good Practice:

- Good involvement of patient and/or family, good documentation, Prompt Consultant review

- Good involvement of patient and/or family, Thorough assessment, Good documentation, Prompt Consultant review, Second opinions sought where appropriate

**SJR Key theme of Areas for Improvement:**

- Improve ED documentation
- Could have been started on IV Antibiotics for possible cold sepsis on admission but delay of 1 day - did not have an impact on outcome.
- Slow response from endocrinology team to a referral regarding thyroid function though this did not impact on outcomes.
- Earlier Tep B review.
- Delayed transfer to ward due to bed capacity, so was in ED for nearly 17 hours.

For further LfD and QIP see section 4.

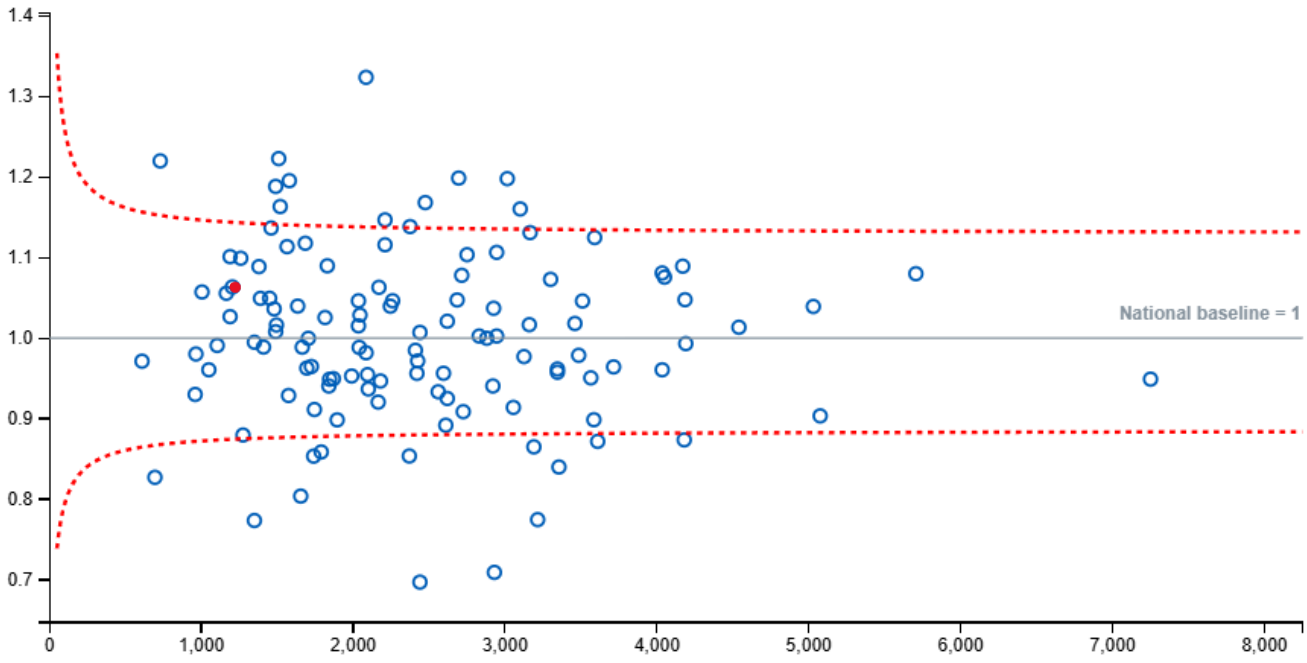
## 2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

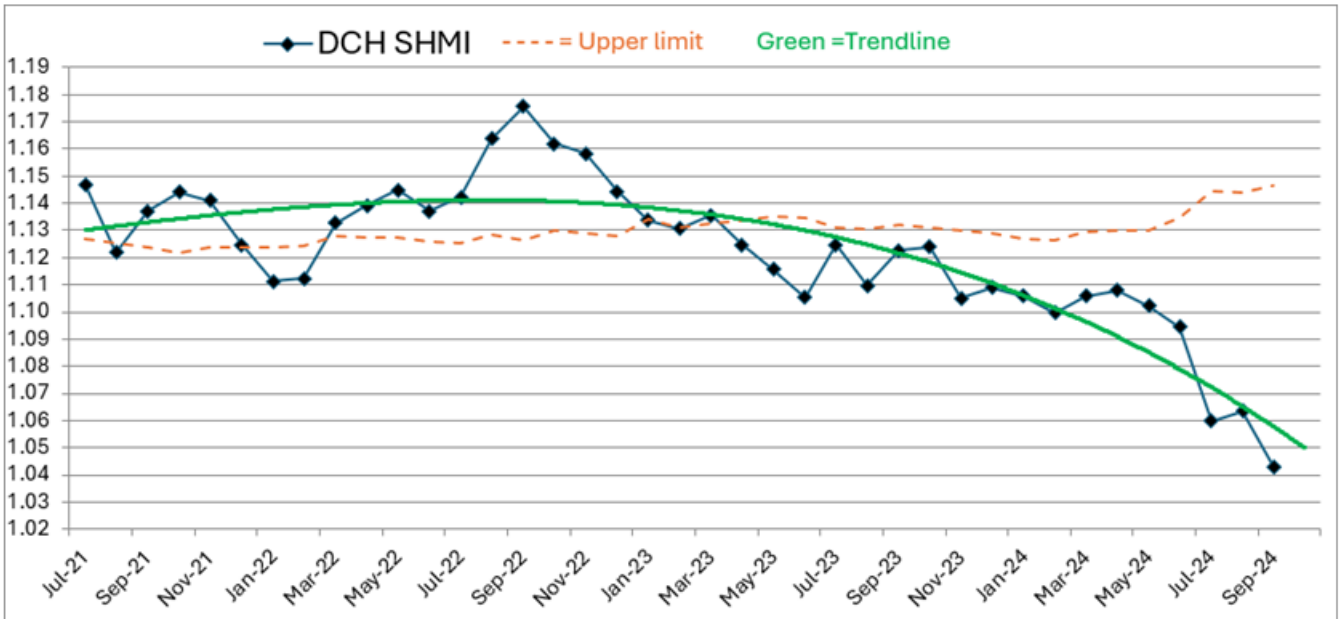
### 2.1 Summary Hospital-level Mortality Indicator (SHMI)

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 for funnel plots from NHS England is for the period Sep 23- Aug 24. **The Trust's figure at that stage was 1.0634. which is within the expected range** using NHS England's control limits. The preview SHMI data for the upcoming publication is even better at 1.043.

DCH =red dot

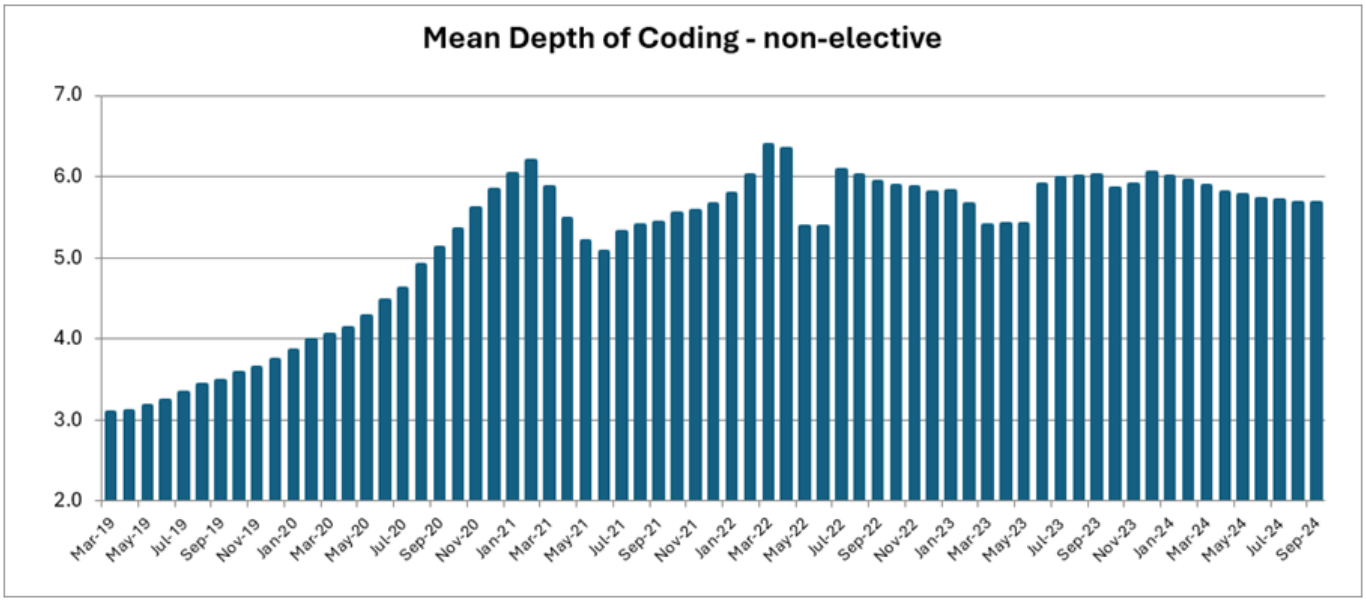





**2.2 Depth of coding:** NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 previously stabilised at around 6.0 – in line with the national average for non-elective admissions. Whilst our depth of coding remains reduced at 5.7, this is relatively static and is not to date impacting SHMI which continues to fall. 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 remains further below the England Average at 5.3(compared to 6.2).

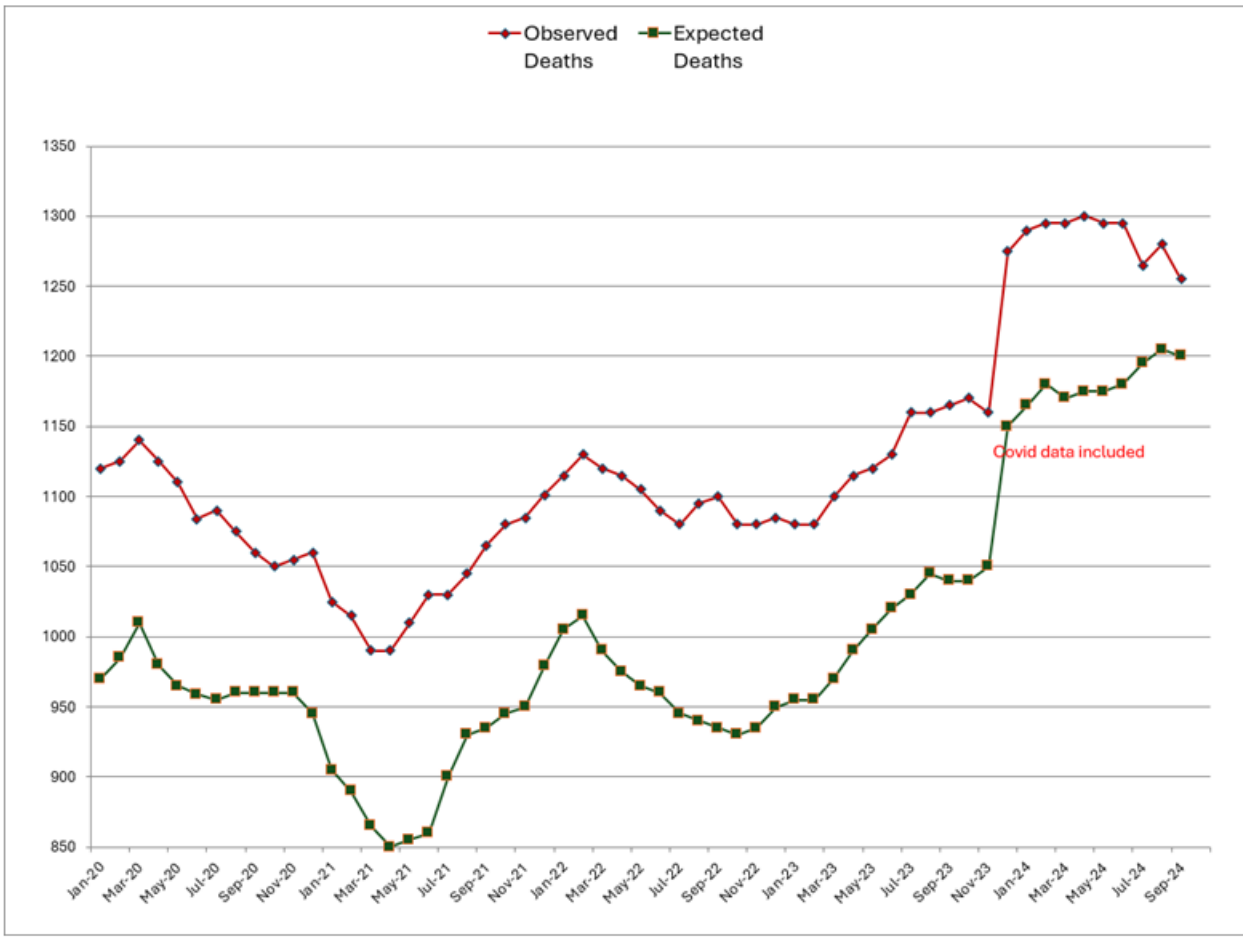
DCH % of provider spells with a primary diagnosis which is a symptom or sign is 15.9 (England average 14.4). This is similar to Q2.



**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.

The number of provider spells has risen again from Q2.




## 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.

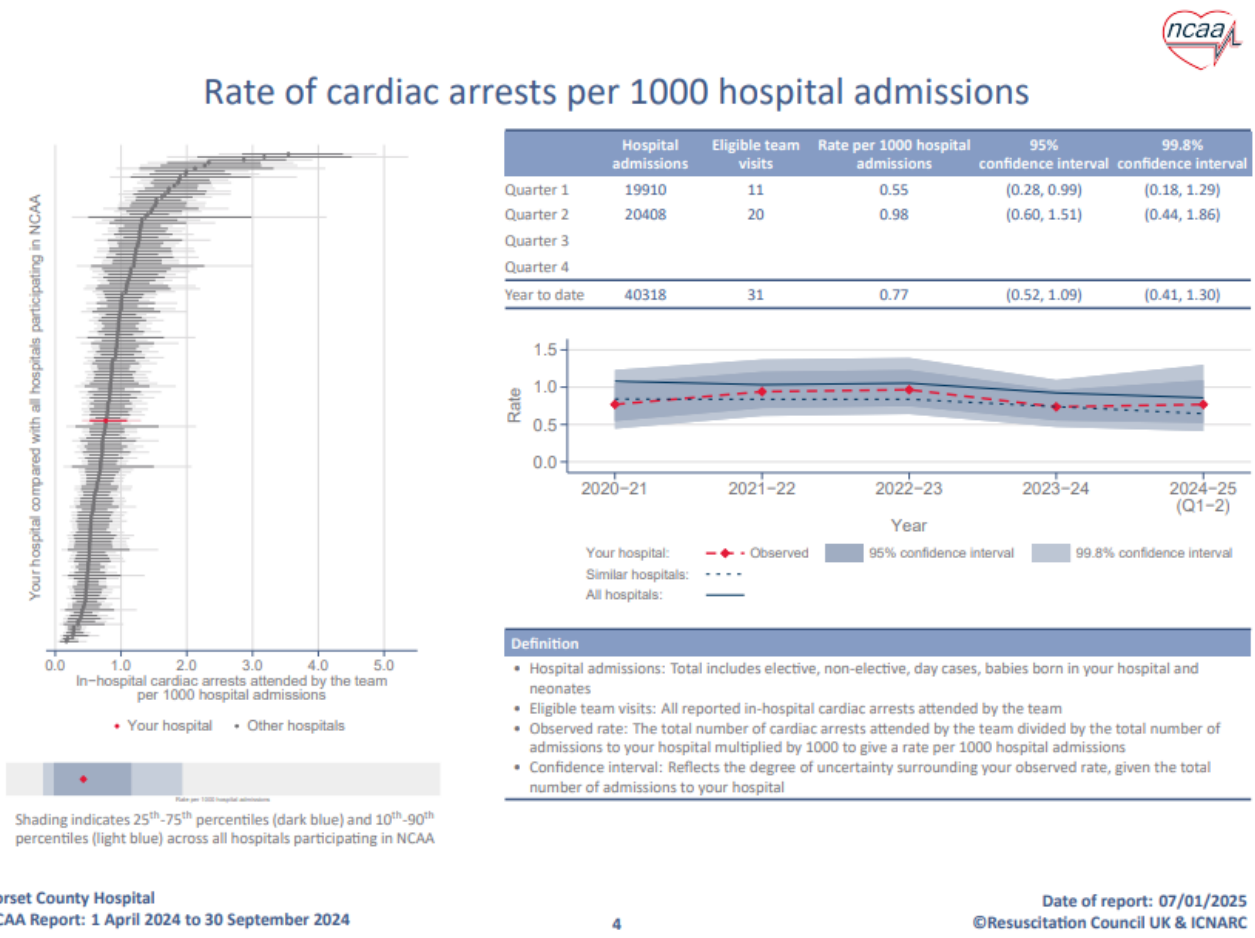
For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

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 Sep 2024 & was published on 07/01/25. 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.

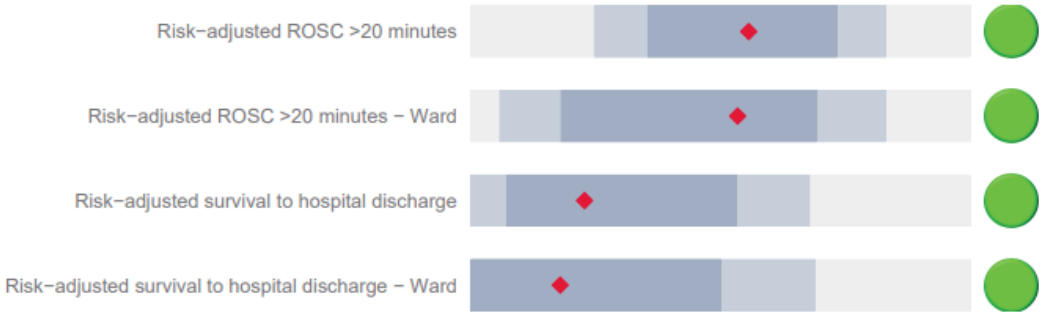
The graph below (left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year.



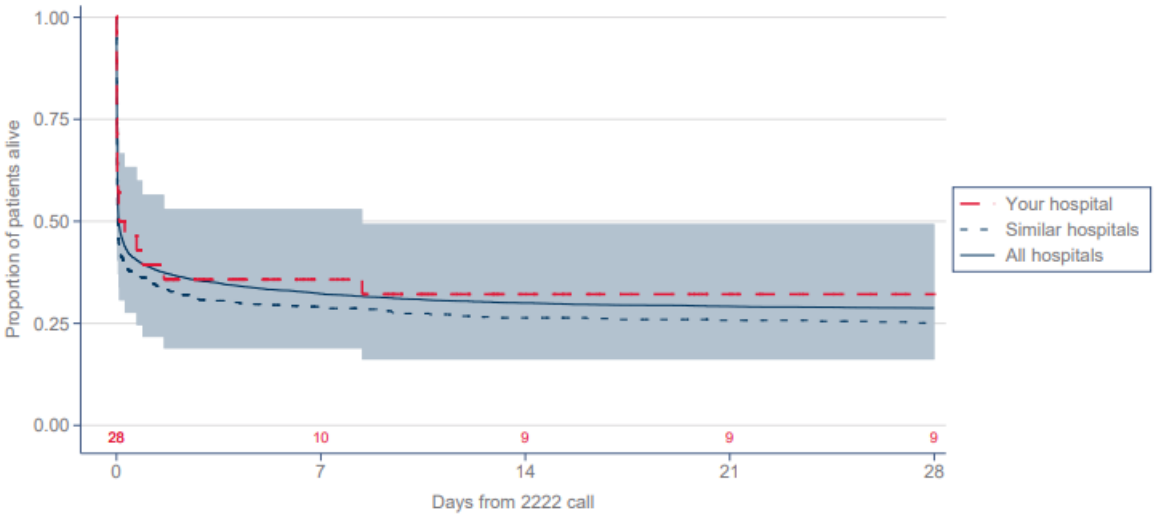

The dashboard below shows two important risk-adjusted outcome measures arising from a cardiac arrest:

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.

## Risk-adjusted outcomes: Dashboard




## Overall 28-day in-hospital survival (K-M plot)




**Explanation**

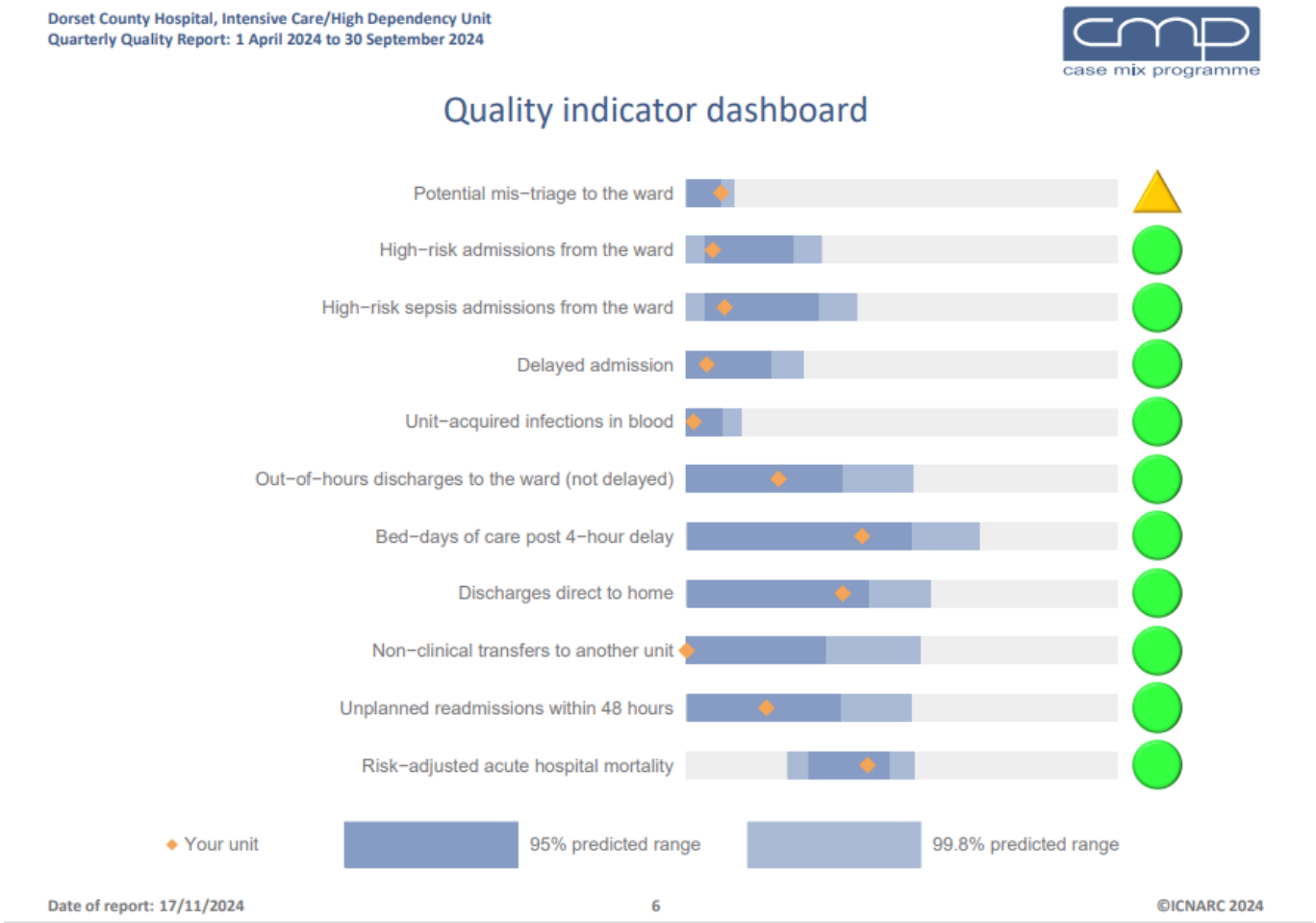
- The Kaplan-Meier (K-M) plot shows the proportion of patients that remain alive by the number of days following 2222 call
- The shaded area shows a 95% confidence interval around the line for your hospital
- The numbers in red at the foot of the figure are the numbers of patients that have not died or been lost to follow-up for your hospital at that time point
- Patients discharged from your hospital before 28 days are assumed to have survived to 28 days

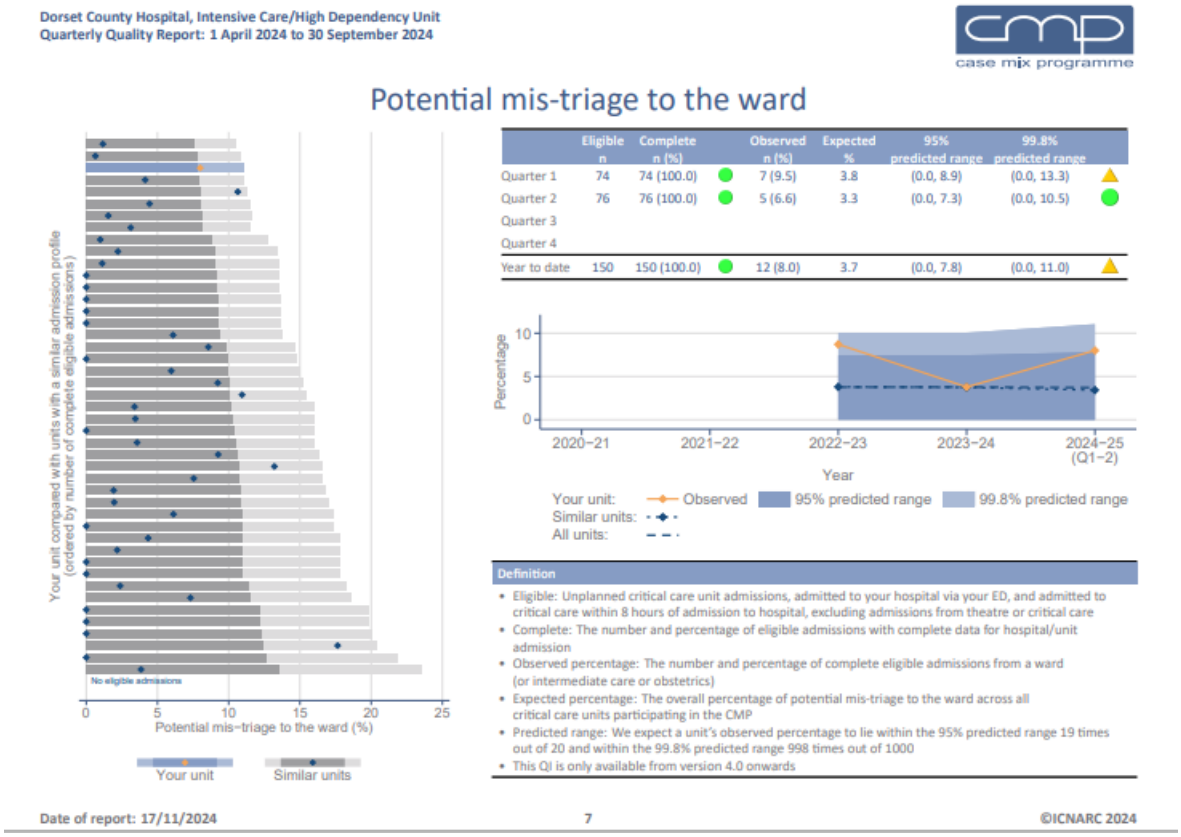



**3.2 National Adult Community Acquired Pneumonia Audit** latest data – last published Nov 2019 and not undertaken for either 2019/20 or 2020/21. Data collection restarted in Spring 2022 but it is unclear whether this has completed.

**3.3 ICNARC Intensive Care survival data** for Q2 dates 1 April 24 - 30 Sep 24 published Nov 2024

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.



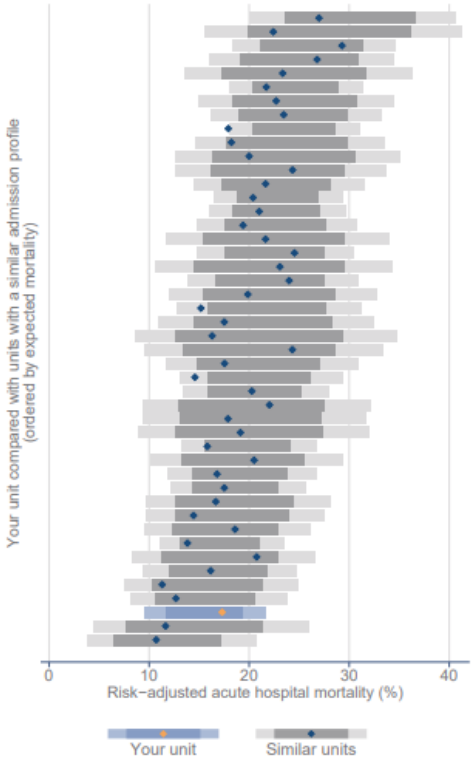



The charts below show the “risk-adjusted acute hospital mortality” following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.

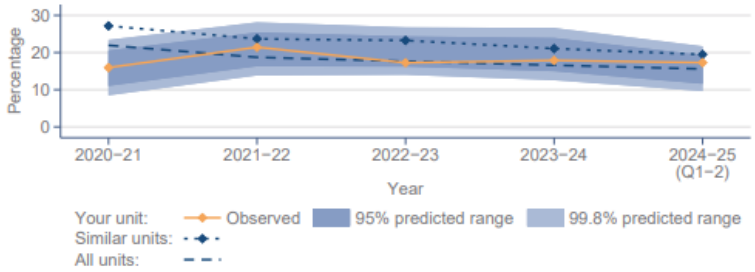
These results are well within the expected range.

case mix programme

# Risk-adjusted acute hospital mortality




| | Eligible n | Complete n (%) | | Observed n (%) | Expected % | 95% predicted range | 99.8% predicted range | |
|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 171 | 171 (100.0) | ● | 29 (17.0) | 15.4 | (9.9, 20.7) | (7.2, 24.2) | ● |
| Quarter 2 | 172 | 170 (98.8) | ● | 30 (17.6) | 15.7 | (10.1, 21.0) | (7.4, 24.5) | ● |
| Quarter 3 | | | | | | | | |
| Quarter 4 | | | | | | | | |
| Year to date | 343 | 341 (99.4) | ● | 59 (17.3) | 15.5 | (11.6, 19.3) | (9.6, 21.7) | ● |



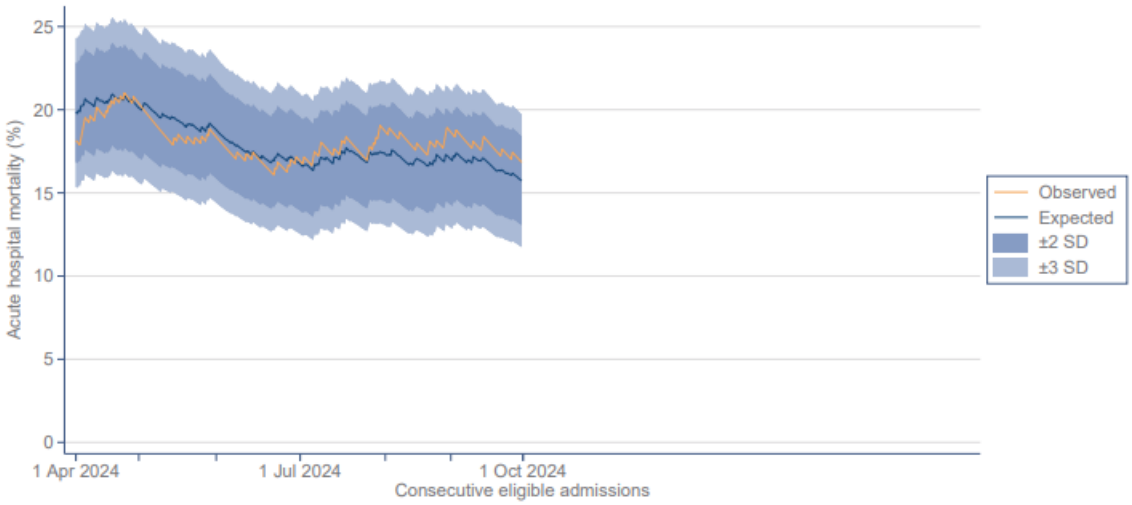

**Definition**

- 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

case mix programme

## Risk-adjusted acute hospital mortality (EWMA plot)

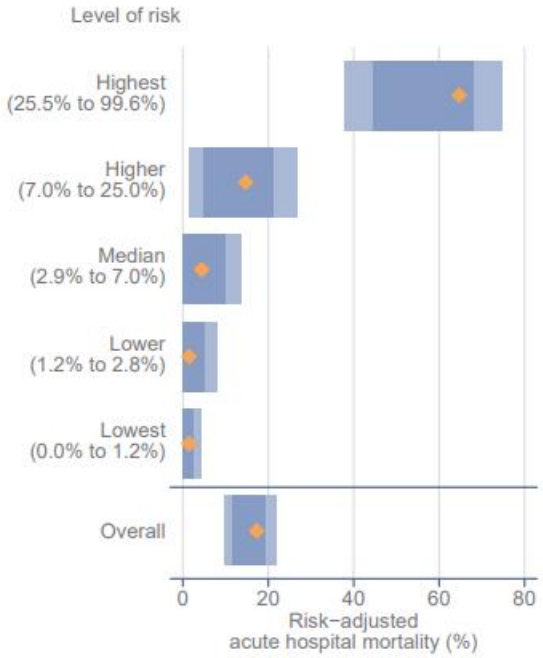



**Explanation**

- 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

# Risk-adjusted acute hospital mortality (by predicted risk)



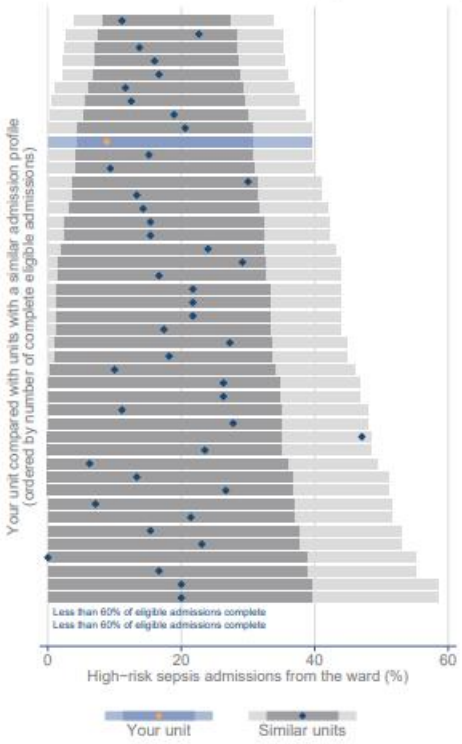

| Level of risk | N | Observed n (%) | Expected % | 95% predicted range | 99.8% predicted range | |
|---|---|---|---|---|---|---|
| Highest | 68 | 44 (64.7) | 57.3 | (44.6, 68.2) | (37.8, 74.7) | |
| Higher | 68 | 10 (14.7) | 13.4 | (5.0, 21.3) | (1.6, 26.8) | |
| Median | 68 | 3 (4.4) | 4.7 | (0.0, 9.7) | (0.0, 13.7) | |
| Lower | 68 | 1 (1.5) | 1.9 | (0.0, 5.0) | (0.0, 8.0) | |
| Lowest | 69 | 1 (1.4) | 0.6 | (0.0, 2.4) | (0.0, 4.3) | |
| Overall | 341 | 59 (17.3) | 15.5 | (11.6, 19.3) | (9.6, 21.7) | |

**Explanation**

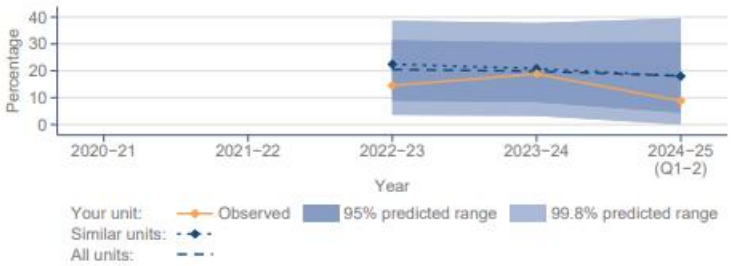
- Risk-adjusted acute hospital mortality (by predicted risk) is designed to help identify patient subgroups in which acute hospital mortality is higher (or lower) than expected
- Admissions are divided into 5 equal-sized groups (or 3 if fewer than 250 complete eligible admissions are available), according 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$_{M-2023}$ 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

case mix programme

# High-risk sepsis admissions from the ward



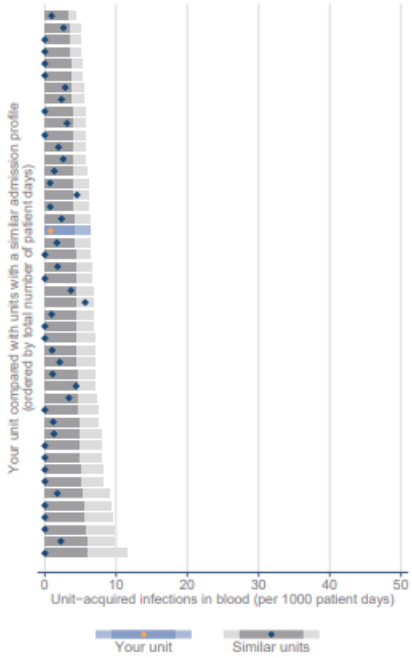

| | Eligible n | Complete n (%) | | Observed n (%) | Expected % | 95% predicted range | 99.8% predicted range | |
|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 18 | 18 (100.0) | ● | 0 (0.0) | 18.5 | (0.0, 35.6) | (0.0, 48.5) | ● |
| Quarter 2 | 16 | 16 (100.0) | ● | 3 (18.8) | 17.0 | (0.0, 34.6) | (0.0, 48.2) | ● |
| Quarter 3 | | | | | | | | |
| Quarter 4 | | | | | | | | |
| Year to date | 34 | 34 (100.0) | ● | 3 (8.8) | 18.1 | (4.4, 30.6) | (0.0, 39.6) | ● |



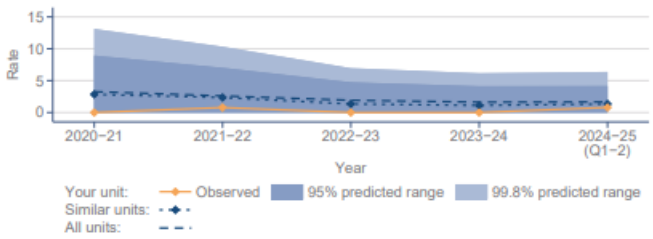

**Definition**

- Eligible: Critical care unit admissions with infection from a ward (or an emergency admissions unit or intermediate care) in your hospital, excluding obstetric and paediatric admissions
- Complete: The number and percentage of eligible admissions with complete data for in-hospital observations prior to referral for critical care expertise
- Observed percentage: The number and percentage of complete eligible admissions with a National Early Warning Score (NEWS2) prior to admission of 10 or more
- Expected percentage: The overall percentage of high-risk sepsis admissions from the ward across all critical care units participating in the CMP
- 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
- This QI is only available from version 4.0 onwards

## Unit-acquired infections in blood




| | Eligible n | Complete n (rate) | Observed n (rate) | Expected rate | 95% predicted range | 99.8% predicted range | |
|---|---|---|---|---|---|---|---|
| Quarter 1 | 95 | 95 (100.0) | 0 (0.0) | 1.7 | (0.0, 5.0) | (0.0, 8.4) | |
| Quarter 2 | 92 | 92 (100.0) | 1 (1.5) | 1.5 | (0.0, 4.3) | (0.0, 7.2) | |
| Quarter 3 | | | | | | | |
| Quarter 4 | | | | | | | |
| Year to date | 187 | 187 (100.0) | 1 (0.8) | 1.7 | (0.0, 4.1) | (0.0, 6.4) | |




**Definition**

- Eligible: Critical care unit admissions staying more than 48 hours
- Complete: The number and percentage of eligible admissions with complete data for unit-acquired infection
- Observed rate: The number of admissions with presence of infection in any blood sample taken for microbiological culture after 48 hours following admission and rate per 1000 patient days (number of admissions divided by the total number of patient days that complete eligible admissions stayed in the critical care unit, multiplied by 1000)
- Expected rate: The overall rate of unit-acquired infections in blood per 1000 patient days across all critical care units participating in the CMP
- Predicted range: We expect a unit's observed rate to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

### 3.4 National Hip Fracture database

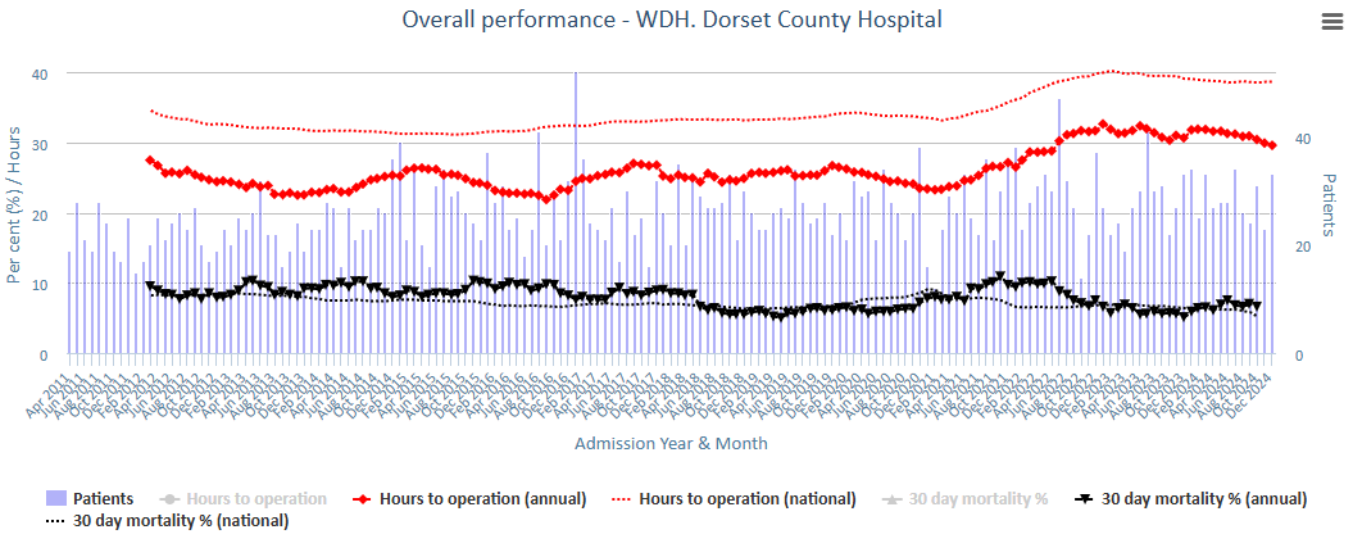
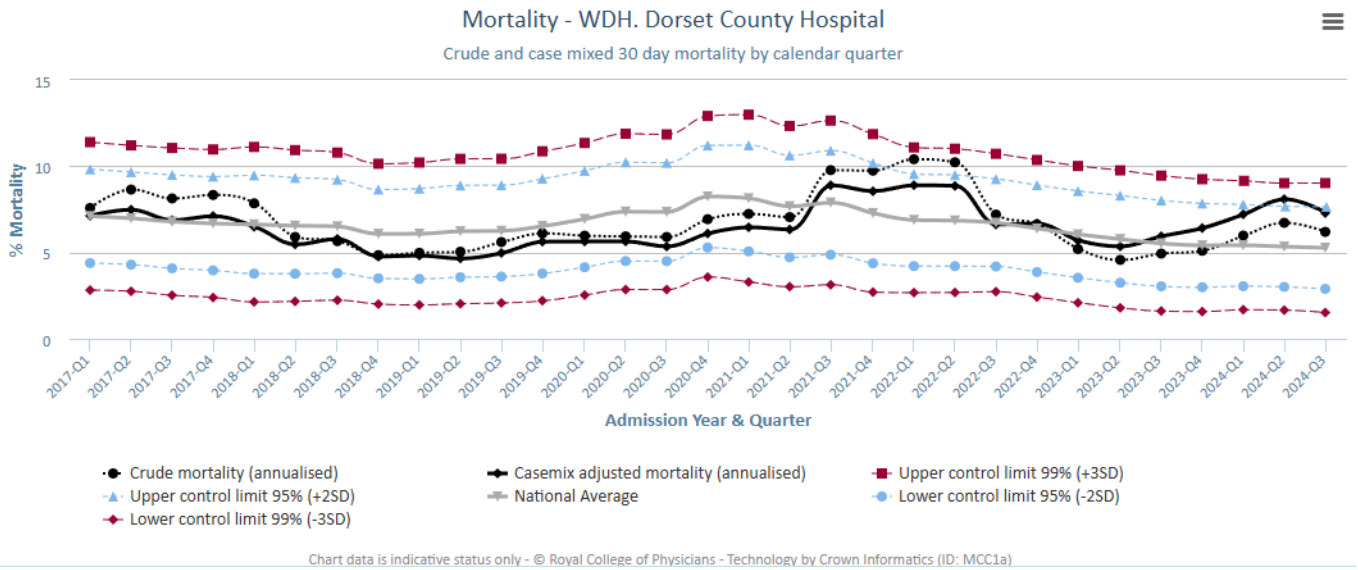



Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: OP14a)

'Hours to operation' remains significantly better than the national average 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:

- Virtual Wards Peer Review DCH DHC & UHD 15.10.25

The following action plans for GIRFT reviews were presented to the Clinical Effectiveness Committee in Qtr3

- TB Services

### 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 2024, which covers child deaths notified and reviewed up until 31 March 2024. https://www.ncmd.info/publications/child-death-review-data-release-2024/

SW estimated child death rate per 100 000 is 24.2 compared to England 29.8. Deprivation and ethnicity continue to have an impact on mortality rates.
Deaths of infants (babies under 1 year of age) accounted for 61% of all child deaths in the year ending 31 March 2024. Estimated infant death rate per 1000 live births was 3.1 for SW region (3.9 England).
Neonatal deaths (deaths of babies under 28 days of age) accounted for 42% of all child deaths in the year ending 31 March 2024. The estimated neonatal death rate for babies born at 24 weeks or over was 1.6 deaths per 1,000 live births of babies born at 24 weeks or over. The neonatal mortality rate ambition is to reduce to 1.0 deaths per 1,000 live births of babies born at 24 weeks or over, by 2025.

DCH is submitting its response to the following national reports:

i) *Learning from deaths of children with a learning disability and autistic children.* Action identified: Flagging for LD or ASD is available on PAS- LD Lead or LD acute Health Facilitator can add once CYP is identified and consent given. Paediatric Reasonable adjustment care plan/ This is Me My Care Passport form part of policy. There are LDA Champions/ Advocates within the Trust. Was Not Brought (WNB) policy recently updated to support effective attendance.

ii) *Child deaths due to asthma or anaphylaxis.* Action identified: Increase awareness of Asthma (Children and young people) - elearning for healthcare amongst DCH staff caring for CYP with asthma via newsletter / email / staff meetings. CPD monitored at appraisal.

Responses will be available on sharepoint in due course.

**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.

PanDorset and Somerset CDOP annual report for 1 April 2023 – 31 March 2024 was presented to the PanDorset Mortality Surveillance Group Feb 2025. Over the past 4 years, the most common category of child death was perinatal / neonatal event followed by chromosomal, genetic, and congenital anomalies.
52% (14/27 reviewed) of deaths had modifiable factors identified. Modifiable factors do not mean that deaths were necessarily preventable. Since 1 April 2024 the panel are having specific focussed case discussions on modifiability with consistent definition applied that is aligned to other CDOPs regionally. Modifiable factors are those which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths. An example of a modifiable factor is smoking in pregnancy when the categorisation of death is recorded as extreme prematurity. We would expect the number of cases with modifiable factors to fall in line with regional peers next year.

NCMD report identified the most common recorded modifiable factors by CDOPs during reviews of infant deaths were smoking by a parent/carer, high maternal body mass index (BMI) and smoking in pregnancy. For deaths of children aged 1 – 17 years factors were poor communication between agencies, 12% of child death reviews (1 – 17 years) with categorised modifiable factors, 4% of all child death reviews (1 – 17 years)), issues with treatment (e.g., delay in starting treatment, side effects or complications developed as a result of treatment, or medical or surgical error) (9%, 3%) and lack of appropriate supervision (e.g., young child unsupervised in a bath) (9%, 3%).

Examples of learning from CDOP reviews include:

- New processes to improve CTG interpretation in maternity
- New parental / guardian self discharge process in ED (East Dorset) & improved paediatric nursing in ED
- Best management of CYP with complex long term health conditions & palliative care
- Enhanced maternity care pathways when parental cannabis identified
- Consistency in care when sensitively viewing deceased children
- Educational update from Police regarding drug use amongst CYP
- Concern re suicide rates in 15-17yr olds across Dorset ( higher than national average) -with focus with schools on suicide prevention

### 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 Q3

### 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.

## 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
3. Update to TEP / DNAR policy almost 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:***

- Reminder of the benefits of performing a Facia Iliaca Block (FIB) in patients with fractured NOF.
- Reminder - Early antibiotics reduces mortality in patients with sepsis.
- For each note entry – a reminder to write date and time as well as signing and printing name.
- A patient waited 5 days for a PICC line for TPN – growing evidence for the need for a funded Trust Vascular Access Service.
- Patient with severe dementia and hoist transfer with community DNAR – This was continued on admission but no TEP form was completed. Please remember to complete TEP when writing or re-writing a DNAR form.
- Excellent practice of MDT discussions around high-risk cases between consultant surgeons and anaesthetists
- Paediatric Asthma/Wheeze pathways – PIER vs SORT. PIER doesn't consider next steps eg. IV MgSO4/aminophylline. This will be reviewed by the PIER team
- Challenges of outdated documents being uploaded onto DPR. Need to ensure we are using the most up to date version of care plans/ACPs etc.
- Raising staff awareness of where to access rarely used emergency drugs (e.g. for inborn errors of metabolism)
- Good escalation of persistent tachycardia and hypotension. Especially in light of patient looking well and stating they felt 'fine'. Fresh eyes reviews helped identify subtle changes to physiology and enable escalation.
- Challenges of obtaining CTA in possible paediatric stroke presentation.
- How do we ensure junior staff can speak openly about management and concerns they may have? Agreement from members that it is acceptable for a junior staff member to contact the Consultant if they have patient and/or staff safety concerns.
- Discussions around restraint and update training.
- Rescue analgesia important. EPMA bundles eg paediatric and adult protocols are available which include pre-med, post op analgesia and antiemetics and TTAs and should be used where possible, when not possible ensure other recovery medication is prescribed.
- Reminder to ensure any unit of a blood product not intended to be given immediately is refrigerated or returned to blood bank to avoid waste.
- Reminder to consider reason for anaemia before transfusing, especially if haemodynamically stable.
- Patient should not be transferred until recovery criteria met unless specifically agreed by anaesthetist or critical care practitioner

- Examples across the Trust of good MDT & family involvement in decisions around conservative management and palliative care.

## 6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of **16** new Coroner's inquests being opened in the period 01 October 2024 – 31 December 2024. We have seen a huge increase in the complexity of the cases.

**28** inquests were held during Quarter 3. **21** inquests were heard as Documentary hearings, not requiring DCH attendance. **6** required a clinician to attend court in person. **1** inquest was held hybrid (some clinicians attending remotely, whilst others attended in person).

**2** pre-Inquest review hearings were held.

We currently have **56** 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, and we have not required Representation.

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.

Clinical Leads have been attending inquests to ensure there is some resilience within the Risk Team.

Learning Identified:

- Improved communication with family about outcomes for elderly patients requiring hip surgery i.e.risks of mortality, when counselling regarding such surgery to the nok as well as elderly patients.
- Improved communication with families around discharge to residential settings, not just the Trusted Assessor (TA).
- Update TA when discharge dates change.

Record significant treatment eg blood transfusion in discharge summaries

## 7.0 LEARNING FROM CLAIMS Q3

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The GIRFT pack for this year has been released, but we identified errors with the data provided. This was highlighted to the national GIRFT team, and they have confirmed that there has been an error with the data stream going into the litigation data packs which they will need to re-validate and then re-share.

Claims pattern Quarter 3 FY 24/25.

| | |
|---|---|
| New potential claims | 17 clinical negligence, 1 employee |
| Disclosed patient records | 36 (19 disclosure for claims inc updated records, 17 disclosures to the coroner) |
| Formal claims | 11 clinical negligence, 2 employee claim |
| Settled claims | 3 clinical negligence, 0 employee claims (Delay in treatment, Consent, Incorrect treatment) |
| Closed - no damages | 1 clinical negligence, 0 employee claims |

## 8.0 SUMMARY

The latest SHMI publication from NHS England is for the period 1 May 2023 – 30 Sep2024. The Trust's figure continues to fall as predicted and is now at its lowest for a significant period at 1.043. This is within the expected range using NHS England's control limits.

We are aware that our data may in future 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.

Further work in progress to support more appropriate identification of those deaths requiring SJR & to facilitate timely completion of SJR within division A.

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