NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, Part 1	
Date of Meeting	10 June 2025	
Report Title	Learning from Deaths Q4 2024/25	
Prepared By	Dr Adam Nicholls	
Approved by Accountable Executive	Dr Rachel Wharton, Chief Medical Officer	
Previously Considered By	Quality Governance Group Quality Committee in Common 27/05/2025	
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. 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	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 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 for the rolling year January to December 2024 is 1.05. This is within the expected range. SHMI data is showing a stable trend at DCH.
- Coding remains a significant risk for our SHMI. There has been a recent decrease in depth of coding but this now appears stable and not further reducing.
- Division A have introduced a new process for SJR completion which is seeing rates of completion increase

Recommendation

Members are requested to:

- Receive the report for **assurance** and **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 4 2024/25 Report

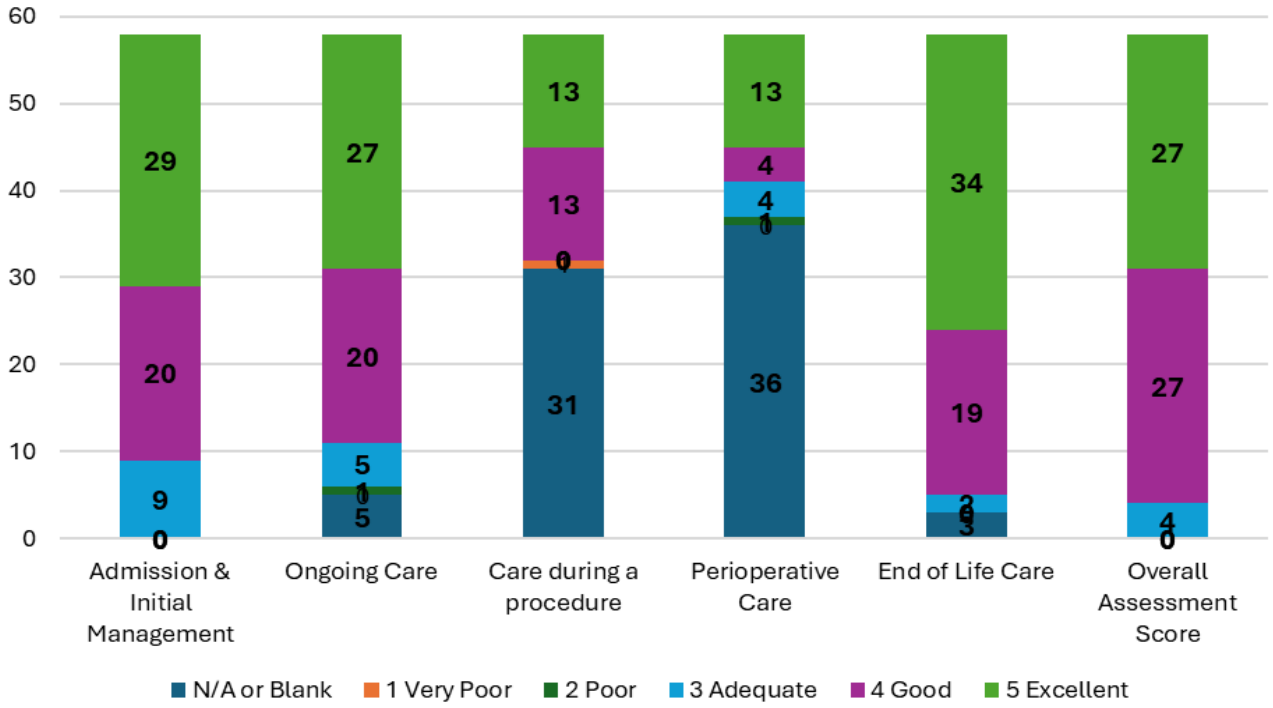
Structured Judgement Review Results:
The Family Services & Surgery Division had 59 deaths in quarter 4, of which 50 that require SJR's to be completed. Within quarter 4 57 SJR's have been completed from this quarter and previous months.

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 30/04/25 is 21:

January	February	March
7	6	8

Feedback from SJR's Completed 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	3	27	44	1	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	2	1	0	1	2
3 Adequate	6	5	5	1	5	6
4 Good	22	22	17	6	26	24
5 Excellent	28	25	7	6	24	25



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	3	3	35	16

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 57 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.
- 1 was for formal documented feedback to Department or clinical team and SJR required – both completed.

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings – completed.
- 1 was for education re escalation of a deteriorating patient.

SJRs are now routinely being completed by both Medical and Nursing staff to provide an MDT approach and ensure all aspects of a case are reviewed.

Emerging themes from Divisional Learning:

1. Missing medications from admission documentation
2. Quality of admission documentation
3. Early signal of delay in NG insertion and then repeated attempts following failure of insertion (this has been shared via the divisional mortality newsletter).

1.2 Division of Urgent & Integrated Care – Quarter 4 Report 2024 / 25

In quarter 4 there were 188 deaths, 39 SJR's were requested from these deaths, and 0 SJR's were completed during this period (completed SJR's not necessarily from this quarter). Division A have started a new process for completing SJRs which saw completion rates increase to 13 in April. Providing this is maintained this will meet the quarterly requirements. Further changes are planned including the allocation of SJRs to all consultants within the division to ensure that the backlog is reduced. This will be monitored to ensure that this progress continues.

	Q4			Q1			Q2			Q3			Q4		
	Jan-24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan – 25	Feb	Mar
Deaths	41	49	41	48	59	65	53	52	45	75	105	82	62	61	66
Deaths requiring SJR'S from Month	14	11	14	9	14	12	15	8	15	6	22	26	7	7	3
***Completed SJR'S**	12	20	12	6	4	0	1	10	9	1	9	2	0	0	0

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

Outstanding SJRs for the Division as at 31/03/2025 is 79 including outstanding nosocomial reviews:

September	October	November	December	Jan	Feb	Mar
26	10	12	14	7	7	3

Phase score from 13 completed SJR's in April 2025:

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	1	12	11	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	1	0	0	0	0
3 Adequate	1	0	0	0	0	1
4 Good	7	6	0	1	3	3
5 Excellent	4	5	1	1	7	9

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
3	0	0	0	10	0

- Clear and concise throughout
- Good, clear plans and documentation
- Records completed. All documentation good. However, the notes are not filed.
- Clumped together and not filed however information was documented when found amongst the bundle.

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	12

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,
- Thorough assessment,
- Good documentation,
- Prompt Consultant review,
- Second opinions sought where appropriate

SJR Key theme of Areas for Improvement:

- Greater focus on advanced care planning would improve patient care
- Some improvements needed in documentation – in particular timing of records
- Flow out of the emergency department means that some patients have a poor experience of care for example waiting for a long time in the department, or deteriorating in the department.
- Earlier Consultant review

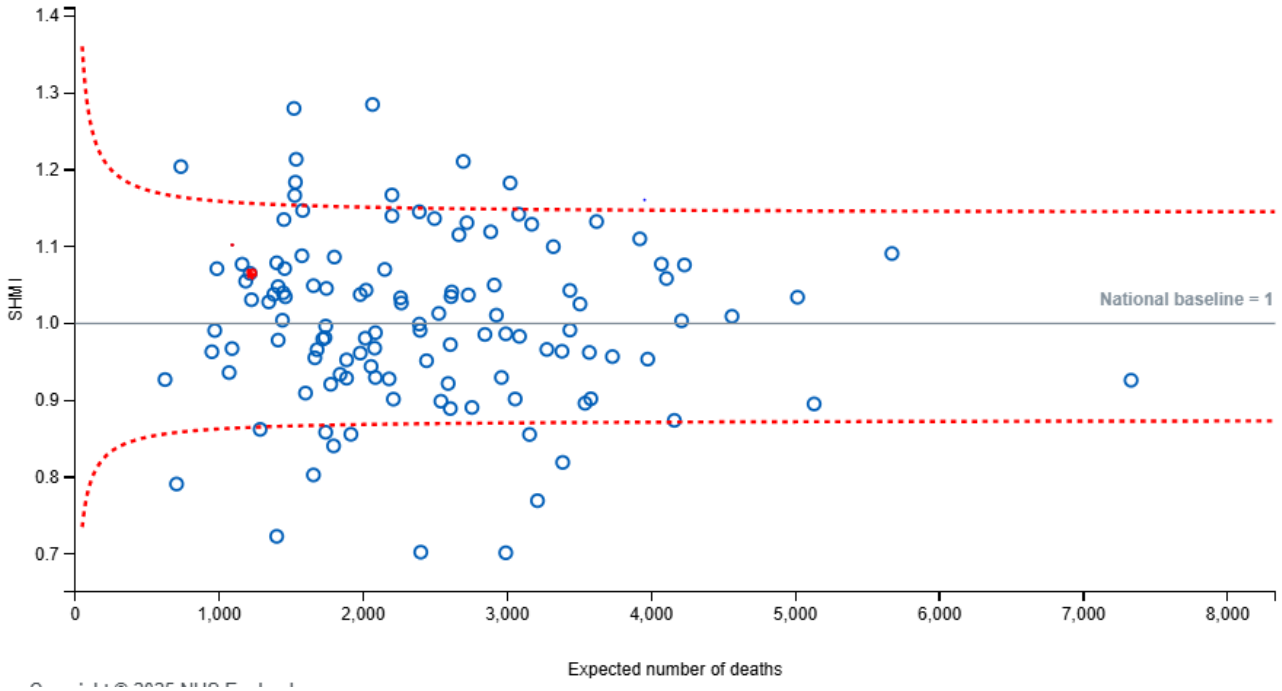
2.0 NATIONAL MORTALITY METRICS AND CODING

2.1 Summary Hospital-level Mortality Indicator (SHMI)

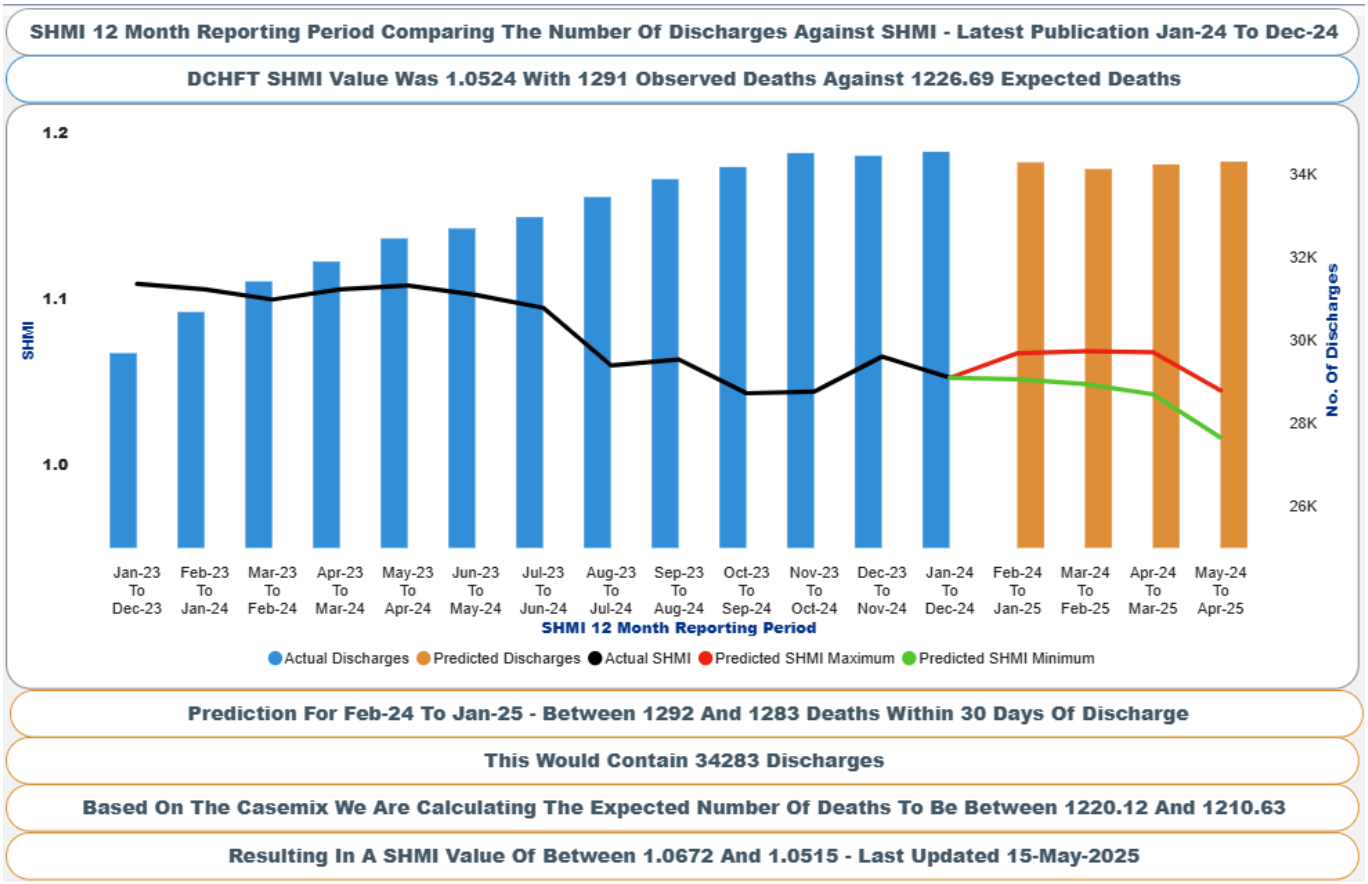
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

The latest SHMI publication for funnel plots from NHS England is for the period January 2024-December 2024 (published 8th May 2025). The trust's SHMI value is 1.05 which is as expected.

DCH =red dot



SHMI data is reported with a 5 month data lag. Our business intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI.



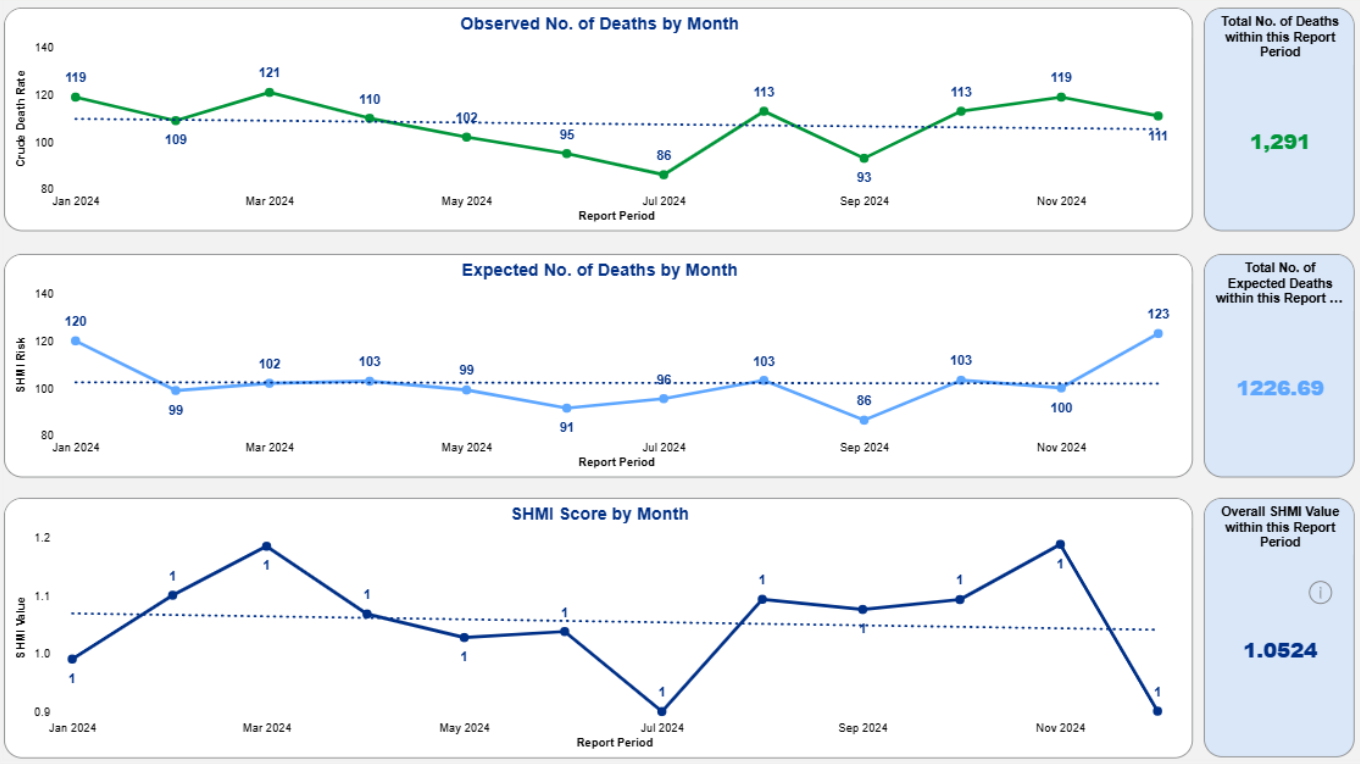
2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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. Our depth of coding remains reduced at 5.7 for non-elective admissions. This remains below the national average of 6.3. This is not impacting our SHMI at present, but needs to be closely monitored. Concerns remain over lack of resource for coding. DCHFT mean depth of coding for elective admissions remains further below the England Average at 5.2 (compared to 6.2), which is a small reduction on quarter 3 (5.3).

DCH % of provider spells with a primary diagnosis which is a symptom or sign is 16 (England average 14.8). This is similar to Q2. This reflects the quality of documentation enabling accurate coding.

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.



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.

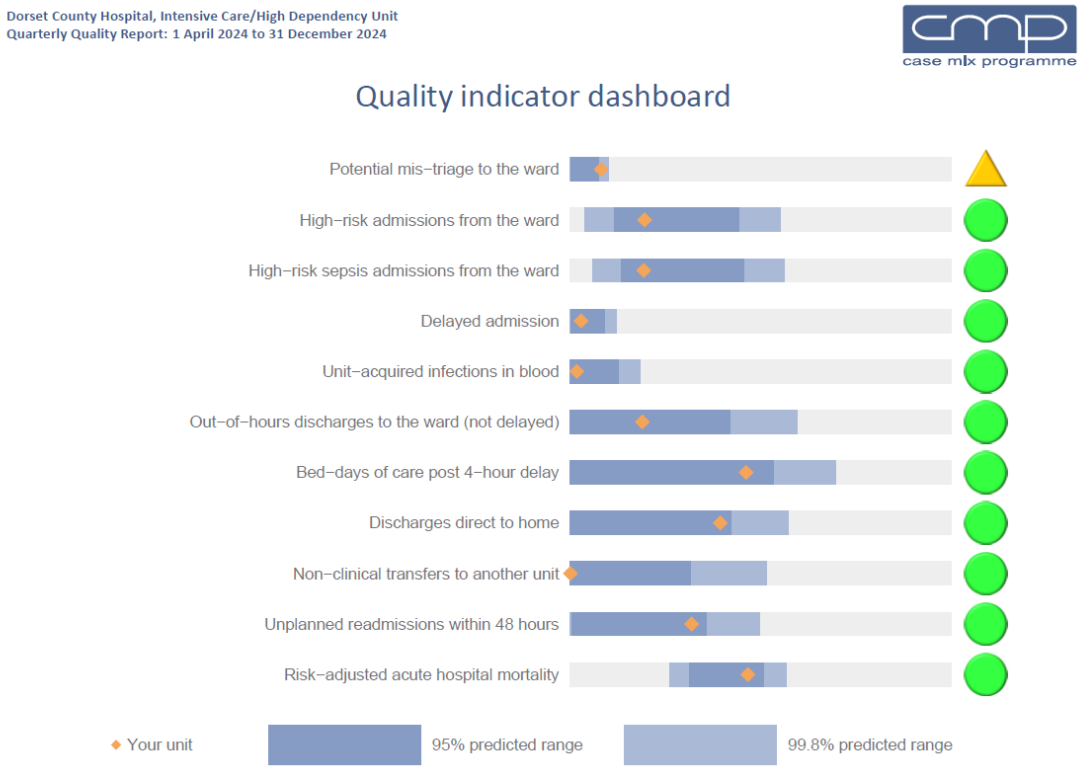
3.1 NCAA Cardiac Arrest data

No new NCAA data has been published since the quarter 3 learning from deaths report. The NCAA data is repoted in 6 monthly periods with the next data release covering 1/10/24-31/03/25. This data is discussed at the resuscitation committee.

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.

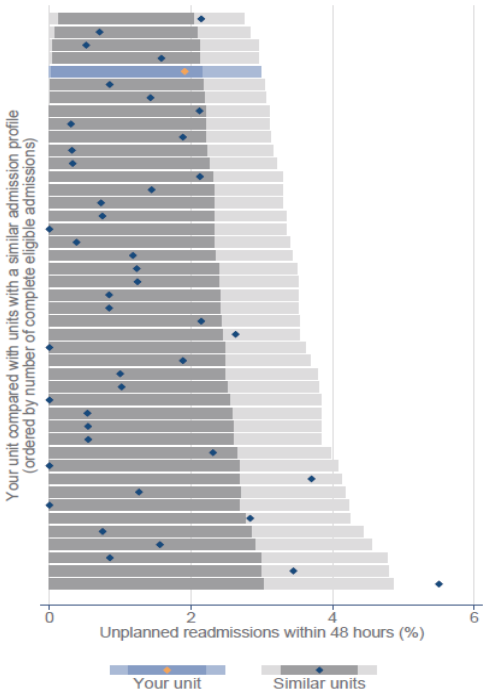
3.3 ICNARC Intensive Care survival data for Q2 dates 1 April 24 – 31 Dec 2024

All but 1 of the indicators remain in the GREEN area. An amber for potential mis-triage to ward has been consistent in the last two data releases, comment is awaited from the intensive care team.

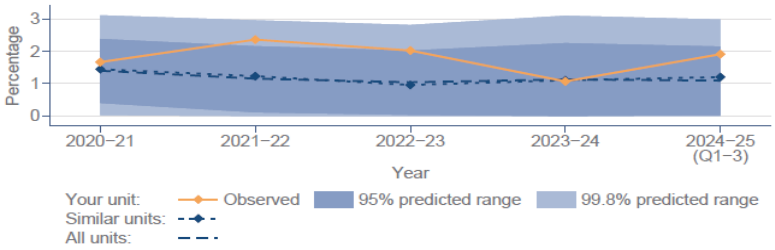


Unplanned readmissions to the unit were higher than expected in this data release:

Unplanned readmissions within 48 hours



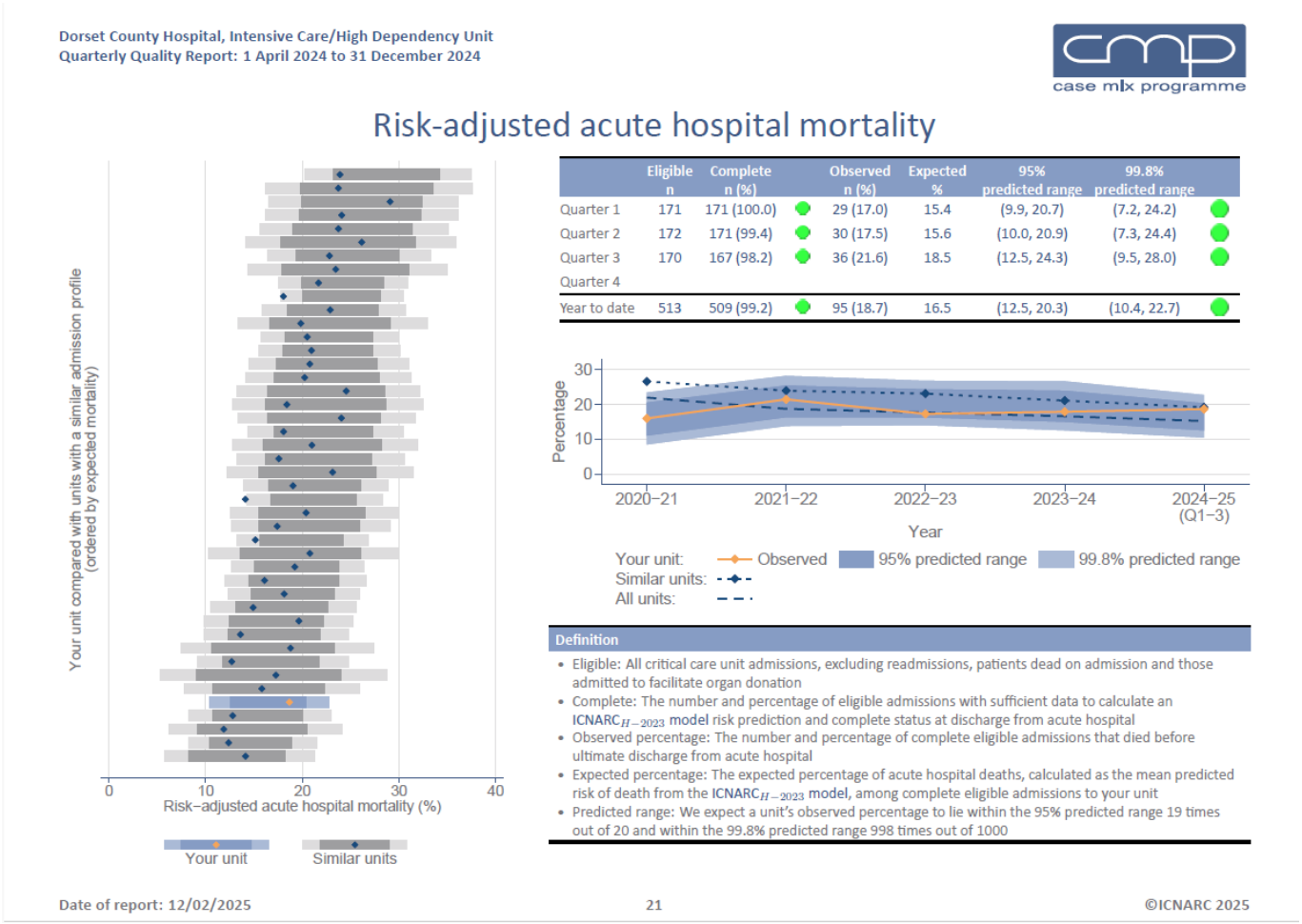
	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	131	131 (100.0)		1 (0.8)	1.1	(0.0, 2.8)	(0.0, 4.4)	
Quarter 2	121	121 (100.0)		2 (1.7)	1.2	(0.0, 3.1)	(0.0, 4.8)	
Quarter 3	114	114 (100.0)		4 (3.5)	0.9	(0.0, 2.6)	(0.0, 4.3)	
Quarter 4								
Year to date	366	366 (100.0)		7 (1.9)	1.1	(0.0, 2.1)	(0.0, 3.0)	



Definition

- Eligible: Critical care unit survivors discharged to a non-critical care location in your hospital
- Complete: The number and percentage of eligible admissions with sufficient data to identify unplanned readmissions
- Observed percentage: The number and percentage of complete eligible admissions subsequently readmitted (unplanned) to your unit within 48 hours of discharge
- Expected percentage: The overall percentage of unplanned readmissions within 48 hours 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

Mortality is within the expected range:

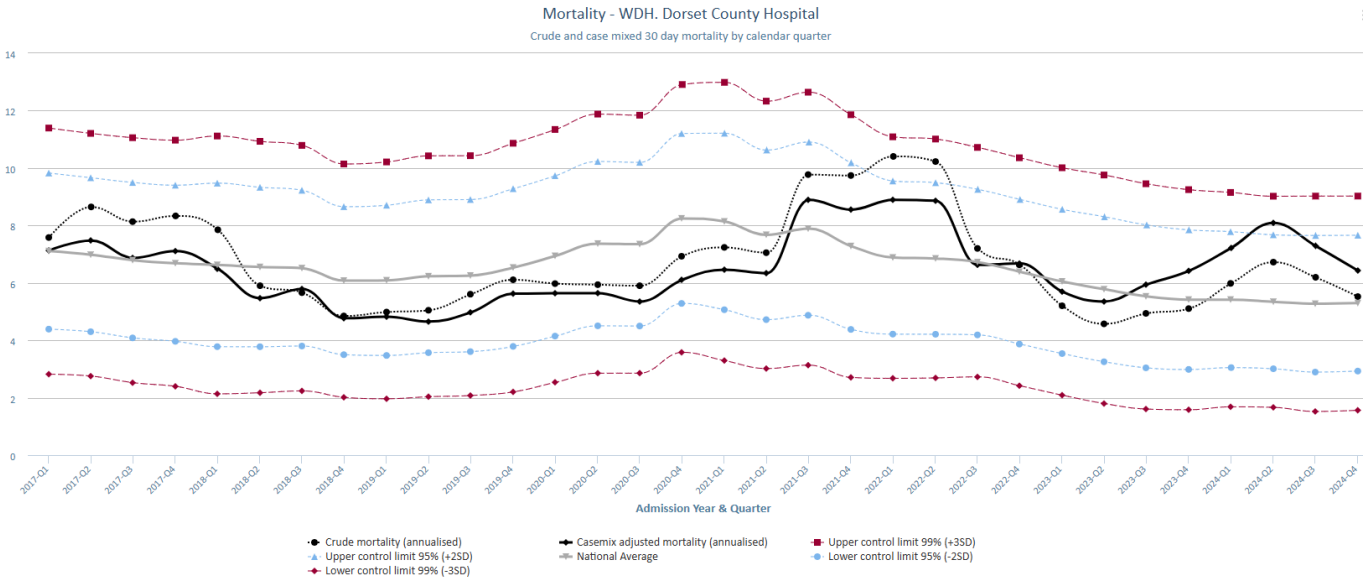


The ICNARC data is discussed in the intensive care clinical governance meeting, and the team are awaiting the publication of the next results before determining whether further work is required.

3.4 National Hip Fracture database

The National Hip Fracture database is run by the Royal College of Physicians, and includes a range of performance data and mortality which I have focussed on below. The annualised case mix adjusted mortality has been above the national average but is showing a sustained improvement from quarter 2 to quarter 4. This is felt to be linked to recording of complexity of case, a data quality issue which has now been resolved. We would expect to see our performance to remain within the expected boundaries, and based on data over time we would expect to track closer to the national average in future.

Our filtered SHMI data for hip fractures show that we are within the expected control limits.



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

- Work is ongoing to ensure that the external review database is up to date to inform reports to committees, and an update will be included in the next report
- Quarter 4 GiRFT reviews/reports
    - There has been a GiRFT report with regards litigation and aspects of this relevant to this report will be included in LfD Quarter 1 25/26 report.
    - Paediatric rheumatology – not applicable to mortality report

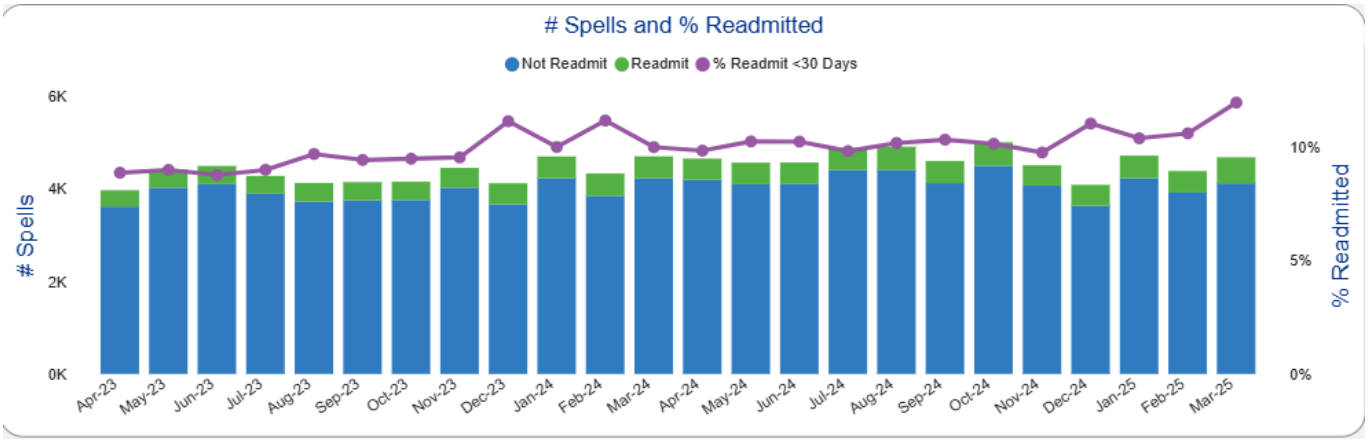
3.7 Trauma Audit and Research Network

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. An update has been requested from the DCH trauma lead to look at what data could be included in future learning from deaths reports.

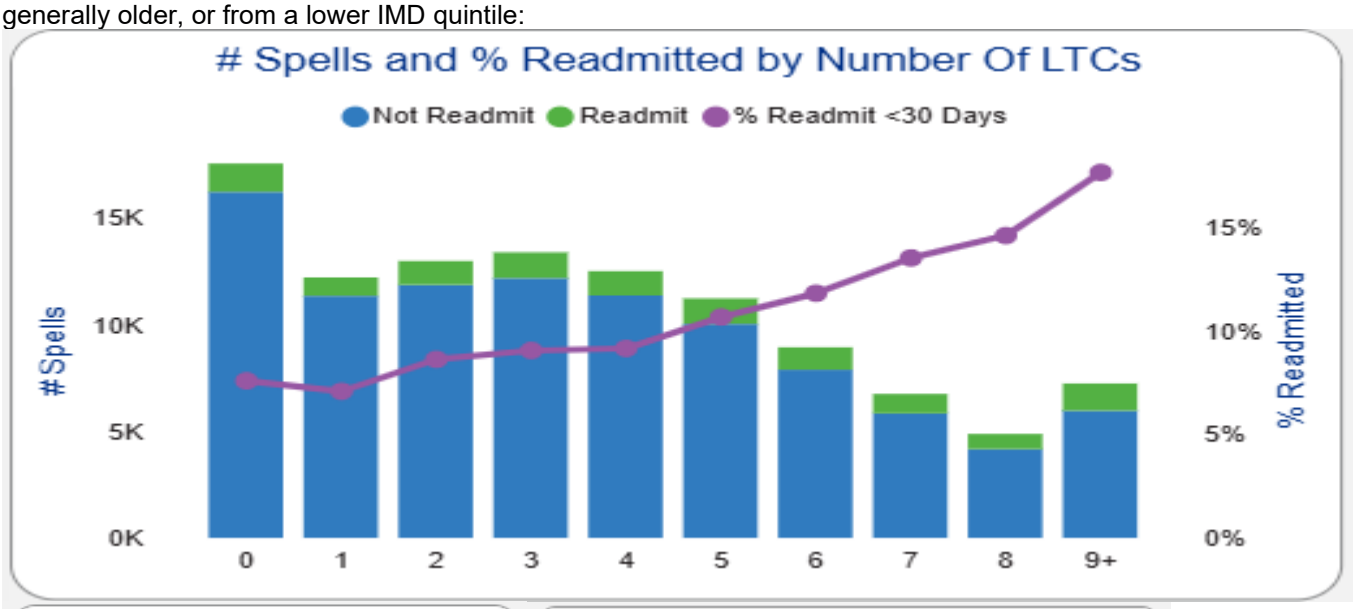
3.8 Readmission to hospital within 30 days

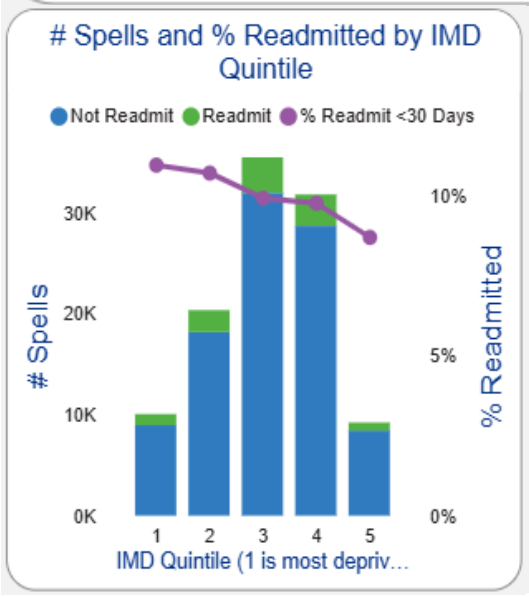
A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process.

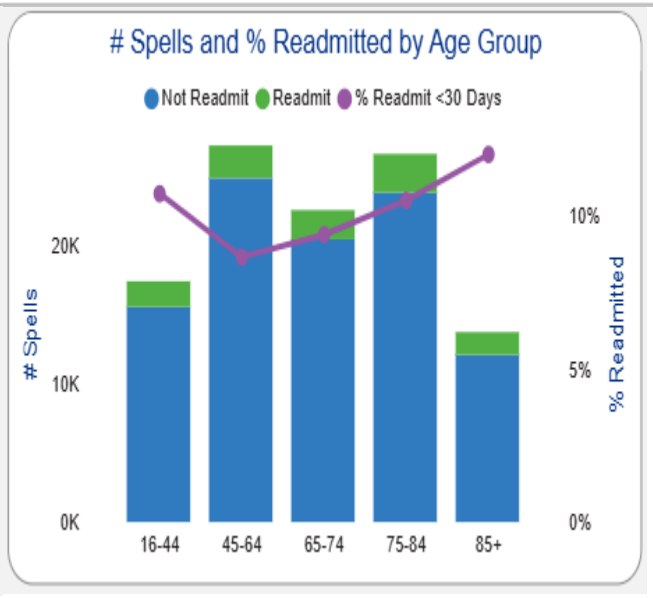
Our readmission rate is rising as shown below, and was 12% in March:



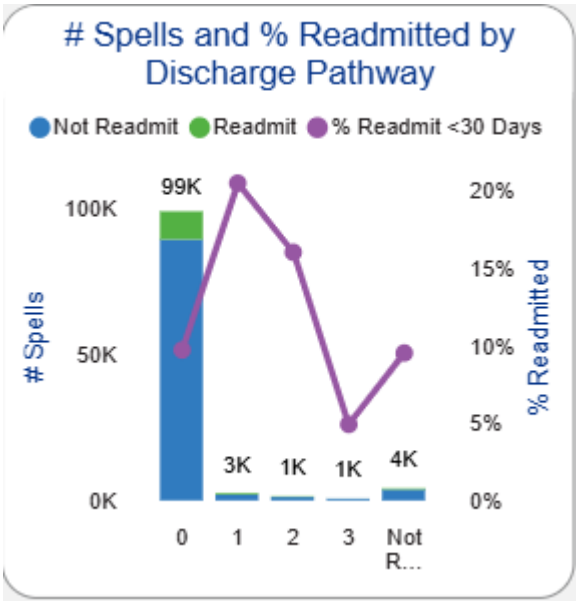
Readmissions are more likely to occur in patients who live with a greater number of long term conditions, are generally older, or from a lower IMD quintile:



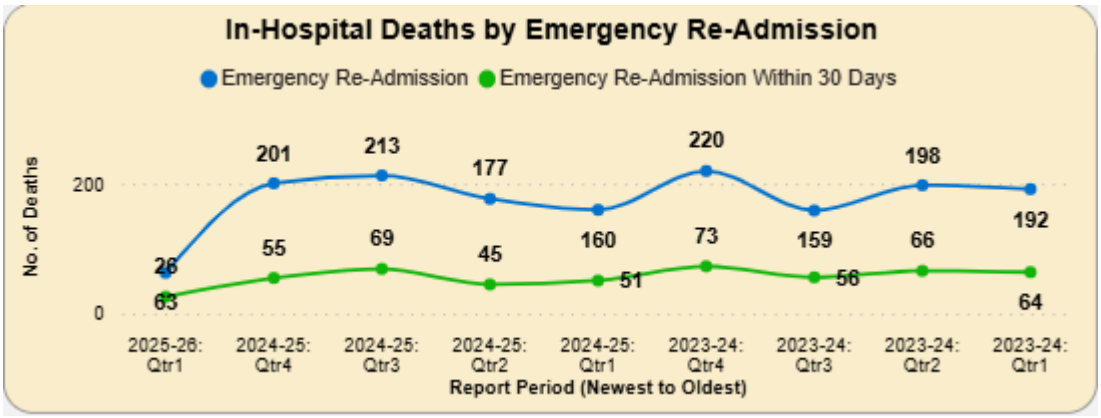




Readmissions are most likely to happen in patients who are discharged requiring short term home based rehabilitation, or social care support at home (pathway 1).



In hospital deaths for patients with an emergency readmission is fairly static, and more work is needed to understand this in the context of the national picture.



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/.

There has been no further data published in quarter 4.

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/

There have been 0 perinatal deaths occurring at DCH reported to MBRRACE-UK via the PMRT in Quarter 4. There has been one late neonatal death reported by a tertiary centre pertaining to a pregnancy booked for care by DCH. This case was reported at the end of Quarter 4, and we are awaiting assignment from the tertiary centre for DCH to input antenatal care.

3.11 National Perinatal Mortality Review tool

Reports | PMRT | NPEU

This is reported separately to board via quality committee in the perinatal mortality review report.

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. New process in Division A for completion of SJRs
2. Quality improvement work has started to ensure appropriate learning from claims/litigation

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:

- Consider early NG tube in patients vomiting with SBO on CT. –
- Avoid repeated attempts at NGT insertion by one healthcare professional. Escalate after a couple of attempts. –
- Two patients with raised lactates of >7 weren't discussed with ICU. Please consider early referral in appropriate patients with lactate >4, especially if it isn't clearing on repeated measurement. –
- An initial CT brain was reported as unremarkable by Hexarad. On further review by local radiologist, there was clear evidence of severe hypoxic brain injury. If the Hexarad report doesn't fit the clinical picture, consider getting it looked at again. –
- EOL care – consider using EOLCP once decision to palliate made and remember to write up PRN meds in patients who have a syringe driver.

- Haematology: Delayed diagnosis despite referral to Neurosurgery in UHS. Biopsy took approximately 6 weeks from initial presentation which should have been the next day – this is a key factor which potentially affected outcome.
- DNACPR not following a patient through to ED and subsequent action taken as this decision wasn't known.

6.0 LEARNING FROM CORONER'S INQUESTS Q4

DCH has been notified of **28** new Coroner's inquests being opened in the period 01 January 2025 – 31 March 2025. We have seen a huge increase in the complexity of the cases.

14 inquests were held during Quarter 4. **10** inquests were heard as Documentary hearings, not requiring DCH attendance. **3** required a clinician to attend court in person. **1** remote. **0** inquests were held hybrid (some clinicians attending remotely, whilst others attended in person).

0 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 on any of the cases.

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

We met with the coroner at the beginning of May, who suggested that Interested Person status does no longer need to be requested in order to gain access to the inquest bundle. The disclosure can be requested under Regulation 27, which means less responsibility for the Coroner and the Trust. The Coroner also confirmed, that where they can they will identify cases that can be open and closed quickly, without the clinician(s) having to hold a date to attend the inquest. This will ensure that clinics do not have to be unnecessarily cancelled.

Clinical Leads have been attending inquests to ensure there is some resilience within the Risk Team. Jodie Crabb, Sonia Gamblen, Dr Rachel Wharton, Dr Adam Nicholls and Miss Audrey Ryan have all now attended at least one inquest each.

Learning Identified:

- Family upset around the lack of communication, being notified 2 hours following a cardiac arrest. Resus team contacted and will include the need for good family communication in their mandatory training sessions. Fedback to Ward Leaders.

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 and we are working towards the 5 point Action Plan.

Claims pattern Quarter 4 FY 24/25.

New potential claims	11 clinical negligence, 0 employee
Disclosed patient records	39 (21 disclosure for claims inc updated records, 18 disclosures to the coroner)
Formal claims	7 clinical negligence, 0 employee claim
Settled claims	4 clinical negligence, 0 employee claims (Failure to remove an infected dialysis cuff, inappropriate handling of patient causing skin tear, excessive removal of foreskin, delay in diagnosing bowel obstruction)
Closed - no damages	7 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period December 2023-November 2024. The Trust's figure remains in the expected range.

Coding remains a challenge, and the clinical coding risk is rated as high on the risk register. The team have implemented strategies for risk mitigation.

We have started to see improvements in the completion of SJRs in division A and a new process is in place and will be monitored.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH. The ICNARC data has highlighted that readmissions to ITU are higher than expected – this data will be monitored and reported in the next learning from deaths report..

More work is required to look into the details of emergency readmissions, although there is no signal at present that we are seeing excess deaths as a consequence of emergency readmissions.