LSEBN ODN Board January 2022
Attachment 01b

LSEBN ODN M&M Audit - Tuesday 20th September 2022

Agenda and estimated timing

Note for attendees.

- *This is a video-conference audit meeting and is for NHS staff involved in specialised burn care.*
- *Each service will present all deaths and all Serious Incidents (SIs), for the period 1st January to 30th June 2022.*
- *Screen presentations, related to individual patients, will be provided and the content must not be shared with others.*
- *During the meeting, and unless you are speaking, please ensure your microphone is muted.*

1	13.00	**Introduction** • Aims and Objectives • Actions and next steps	*DB*
2		**Network Mortality & Morbidity Audit 2021** *(Timings approximate)*	*Clinical leads from each service*
	13.05	Oxford John Radcliffe	
	13.20	Stoke Mandeville Hospital	
	13.45	Queen Victoria Hospital	
		A 10 minute comfort break	
	14.20	Chelsea & Westminster Hospital	
	15.20	St Andrews Broomfield Hospital	
3	16.20	**Confirmation of cases moving forwards to National Audit meeting (April 2023)** • *Cases agreed today for the period January to June 2022*	

Next Audit meetings:
❖ *LSEBN Network M&M Audit: March 2023 to be agreed*

In attendance

David Barnes – St Andrews (Chair and Clinical Lead)
Vicky Dudman – Network Lead Therapist
Niall Martin – Burns Surgeon St Andrews
Joanne Atkins – Clinical Lead ChelWest
Paul Drake – Clinical Lead QVH
Alex Murray – Clinical Lead Stoke Mandeville
Alex Baldwin – Stoke Mandeville
Sara Atkins – Clinical Lead Oxford
Hodan Abdi – IBID Coordinator ChelWest
Joanne Pope – NHSE East of England
Nicole Lee – Network Lead Nurse
Hassan Mohammed – Burns Fellow St Andrews
Alex Dudbridge – Ward Manager ChelWest
Suzie Whiting – Stoke Mandeville
Alison Munday – Quality Team QVH
David Cussons – Stoke Mandeville
Fadi Issa – Burns Surgeon Stoke Mandeville
Amy Brownlee – IBID Coordinator QVH
Michael Wiseman – IBID coordinator St Andrews
Pete Saggers – LSEBN Network Manager

Short notes

1 Chairs introduction and apologies

DB welcomed all to the meeting. PS made a general statement about the need for confidentiality during the meeting and reiterated that the meeting was only for NHS staff involved in specialised burn care. This includes the NHSE Regional and National Commissioners, who are welcome to join and participate in the meeting.

2 As is the case for all of the network and national M&M Audit meetings, there are no formal written notes of the meeting. This is because of the sensitive nature of patient information that is discussed. The purpose of the audit is to add a layer of governance and scrutiny to the existing burn service & hospital audit function, and to support services and networks in sharing experiences and good practice, with the aim of improving patient outcomes and quality of care. Participation in Network and National Mortality Audit is a requirement for all specialised burn care services.

3 The audit period was six months, January to June 2022. The Audit format includes the following information, separated for adults and children:

- A summary analysis of activity (patient referrals)
- Analysis of resus cases, with or without ventilation
  These are sub-analysed for burns cases and non-burns skin loss cases
- Case analysis of any serious incidents
- Case analysis of all mortalities
  Mortalities are categorised as follows:
  - *Expected mortalities / Comfort care*
  - *Out of service mortalities*
  - *Unexpected or actively treated cases*

4 Each of the five specialised burns services in the network gave a presentation on activity, serious incidents and mortalities.

One case was not presented. The host Trust had asked that one case was not discussed until the official coroner's report became available. This case will be included in the next network M&M audit meeting (March 2023).

5 One of the objectives for the network audit meeting, is to identify cases for the national Mortality Audit meeting. All Serious Incidents and all mortalities in children are presented at the national meeting. Additional (adult) cases for the national meeting are usually those that are either:

- Unexpected or outlier cases (low Modified Baux Score or other indicators of morbidity).
- Cases that have significant learning / educational opportunities for a wider audience.

  - ***From the presentations, it was agreed that three cases would go forward to the national meeting.***

6 The process of audit allows aspects of the care pathway and treatment of burns to be discussed. In regard to non-patient specific issues discussed at the meeting, two areas were noted:

- The need to look nationally at the burns pathway for ECMO
- The significance of alcohol dependence and associated co-morbidities.
- The continued significance of frailty and obesity

These issues will be discussed with colleagues in the National Burns ODN Group and may be taken up as part of a national work programme.

7 The next series of audit meetings are:

- ***LSEBN Network M&M Audit:*** *Thursday 23rd March 2023*

- ***NBODNG National M Audit:*** *Monday 24th April 2023 to be agreed*