SUPPLEMENTARY INFORMATION: HOW WE LEARN FROM DEATHS Q3 2023-24:

APPENDIX A

1.0 Summary of Hospital Deaths

1.1 Mortality data for total deaths within SaTH managed by the Medical Examiner Service, including a breakdown of inpatient deaths and deaths that occur in the Emergency Department are shown below. Charts 1 to 3 show the data by month and charts 4 to 6 show the data by quarter.

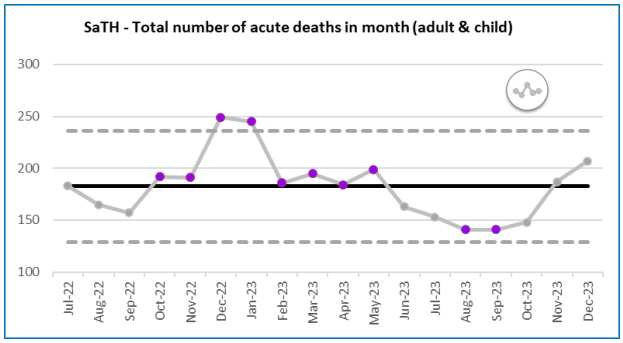


Chart. 1

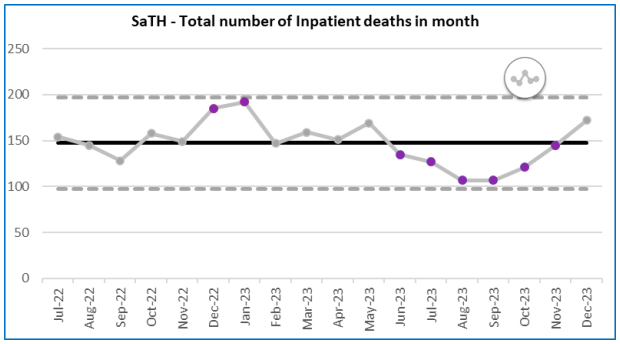


Chart. 2

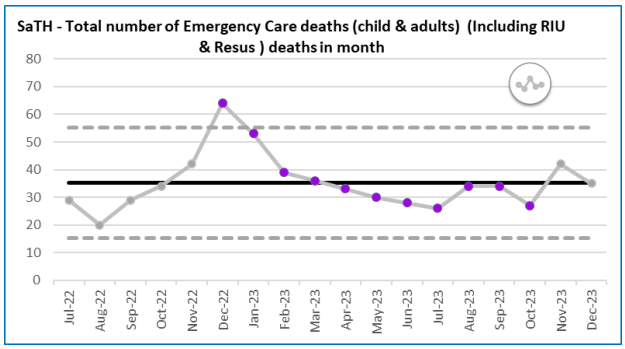


Chart. 3

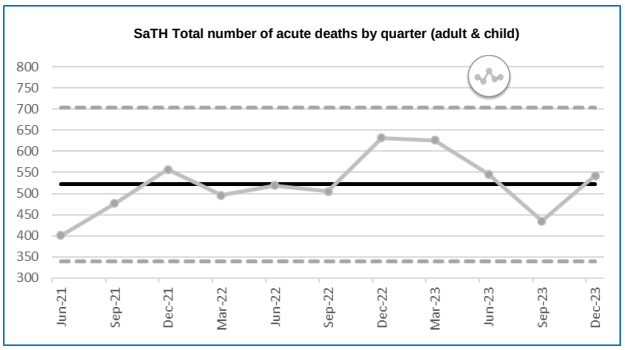


Chart. 4

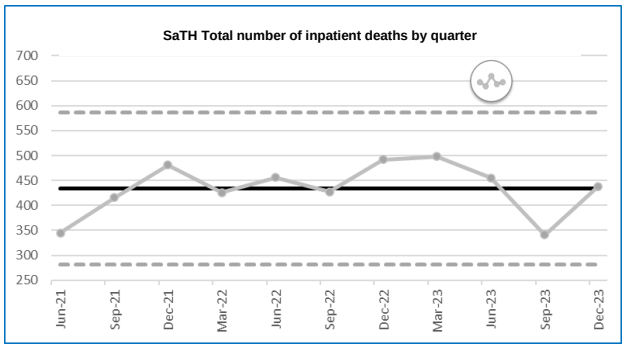


Chart. 5

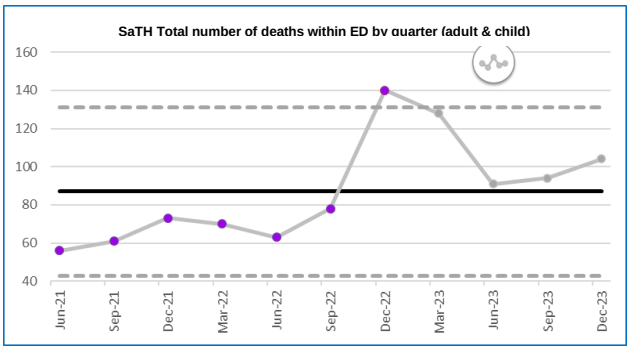


Chart. 6

SUPPLEMENTARY INFORMATION APPENDIX A (ctd)

1.2 Mortality data by site:

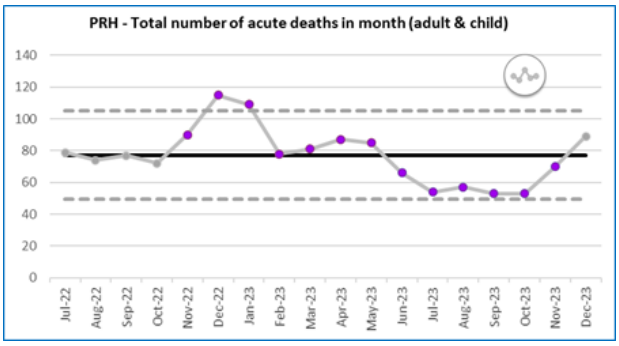


Chart. 7

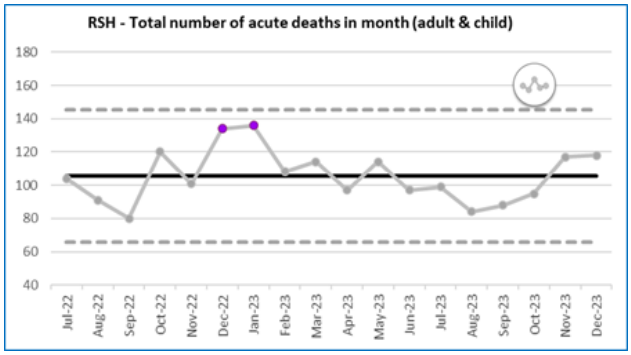


Chart. 8

1.3 Divisional mortality data:

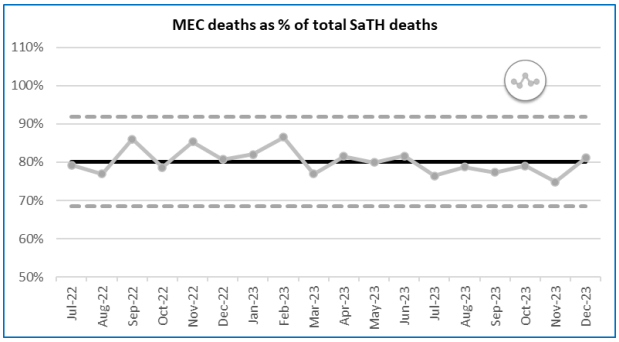


Chart. 9

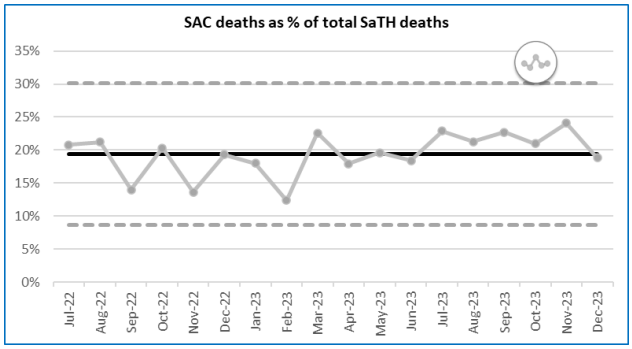


Chart. 10

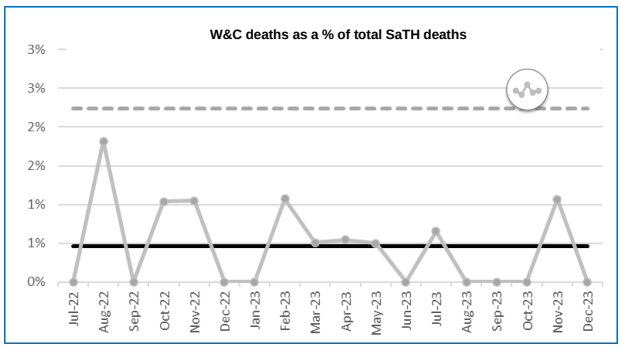


Chart. 11

1.4 CHKS crude mortality and non-elective crude mortality trend:

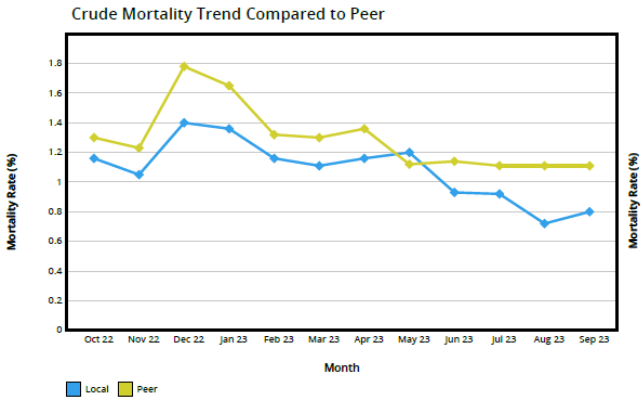


Chart. 12

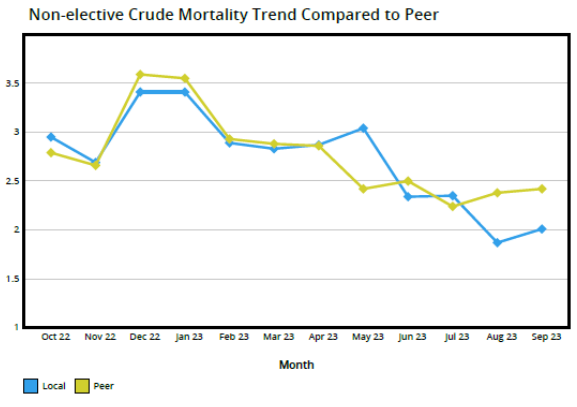


Chart. 13

SUPPLEMENTARY INFORMATION APPENDIX A ctd

1.5 Paediatric deaths within the Trust, including children who have died either as an inpatient or in the ED.

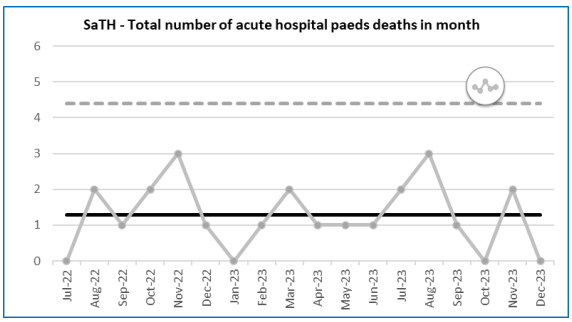


Chart. 14

1.6 Summary Hospital-level Mortality Indicator (SHMI):

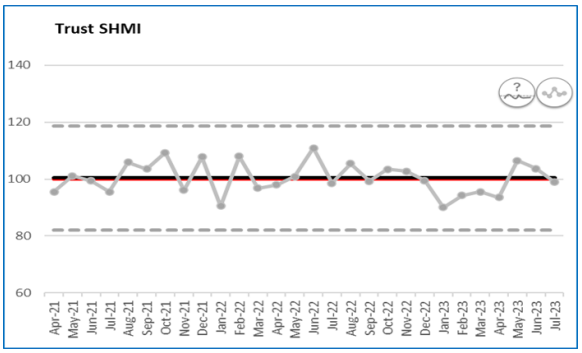


Chart. 15

1.7 SHMI observed versus expected deaths

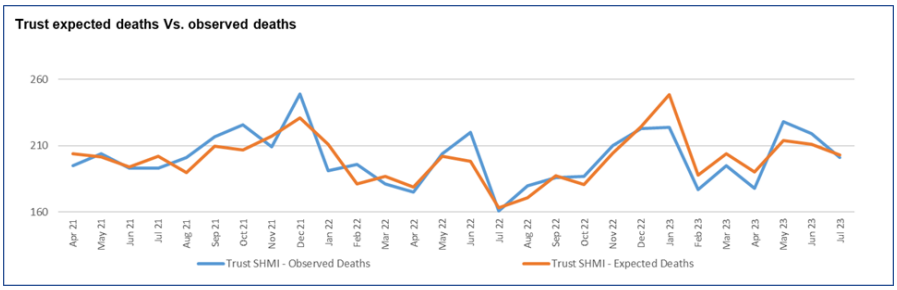


Chart. 16

1.8 Structured Judgement Reviews completed by month with a variable date of death.

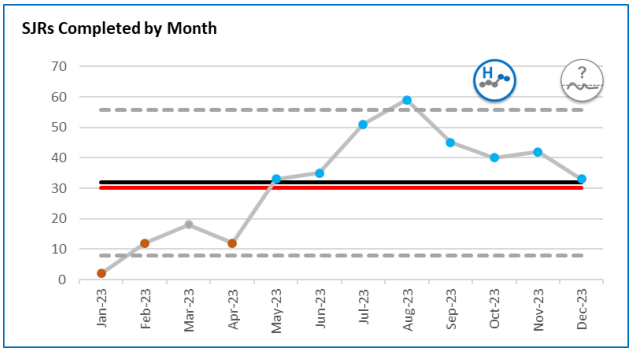
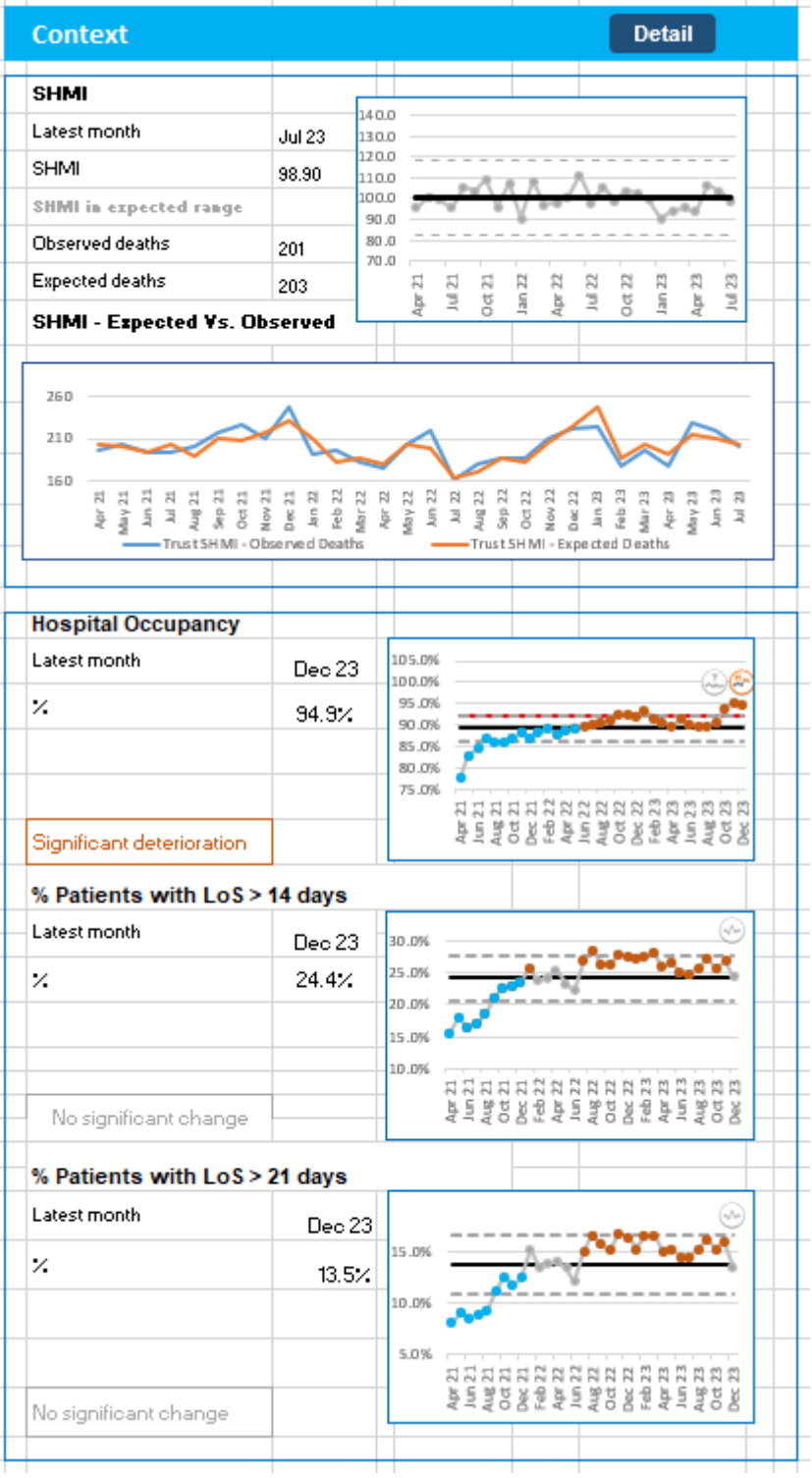


Chart. 17

SUPPLEMENTARY INFORMATION

APPENDIX B Overview of the Learning from Deaths Dashboard - Context, Scrutiny to SJR, Care

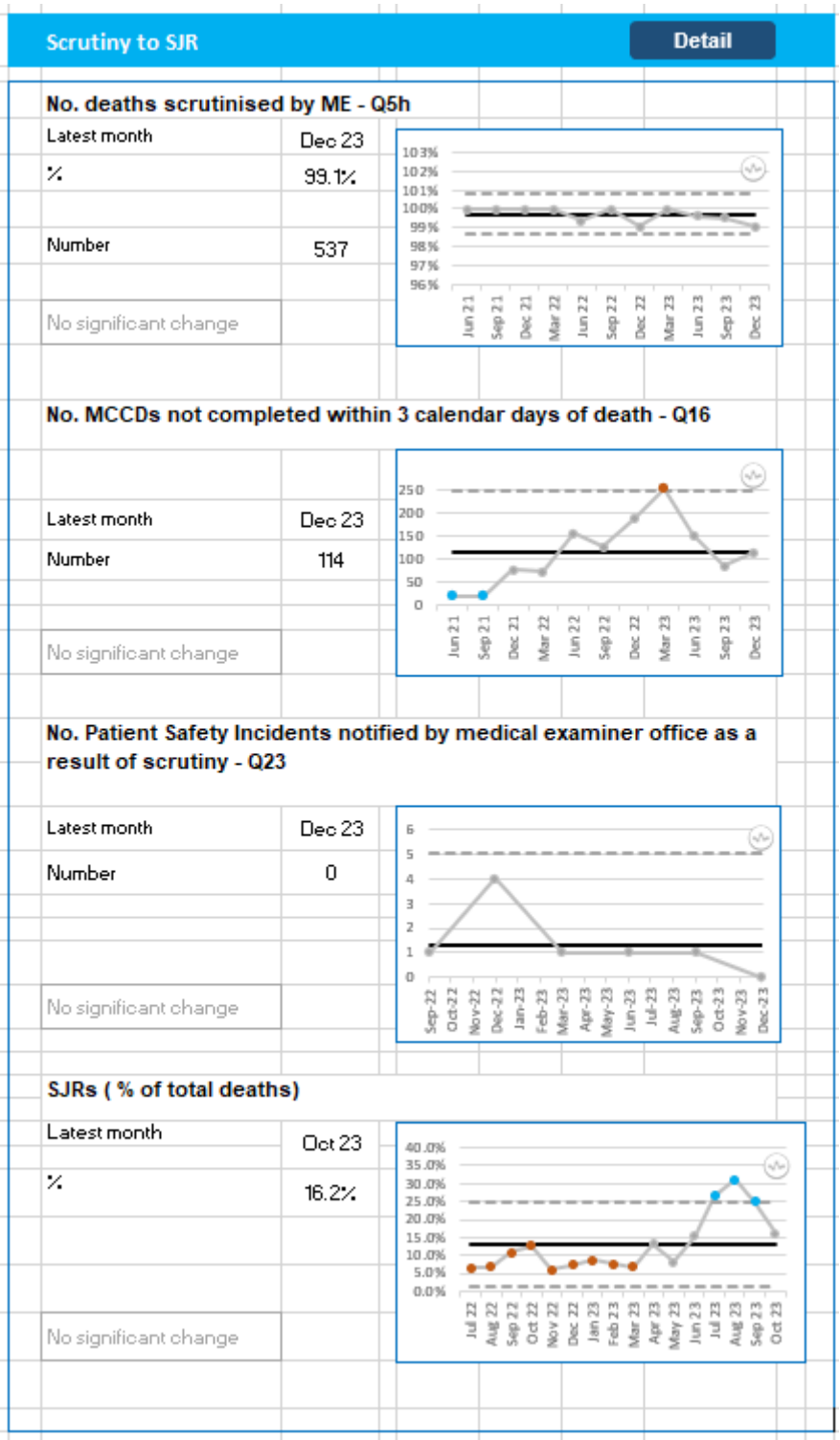
1. **Context**



SUPPLEMENTARY INFORMATION APPENDIX B

APPENDIX B Overview of the Learning from Deaths Dashboard - Context, Scrutiny to SJR, Care (ctd)

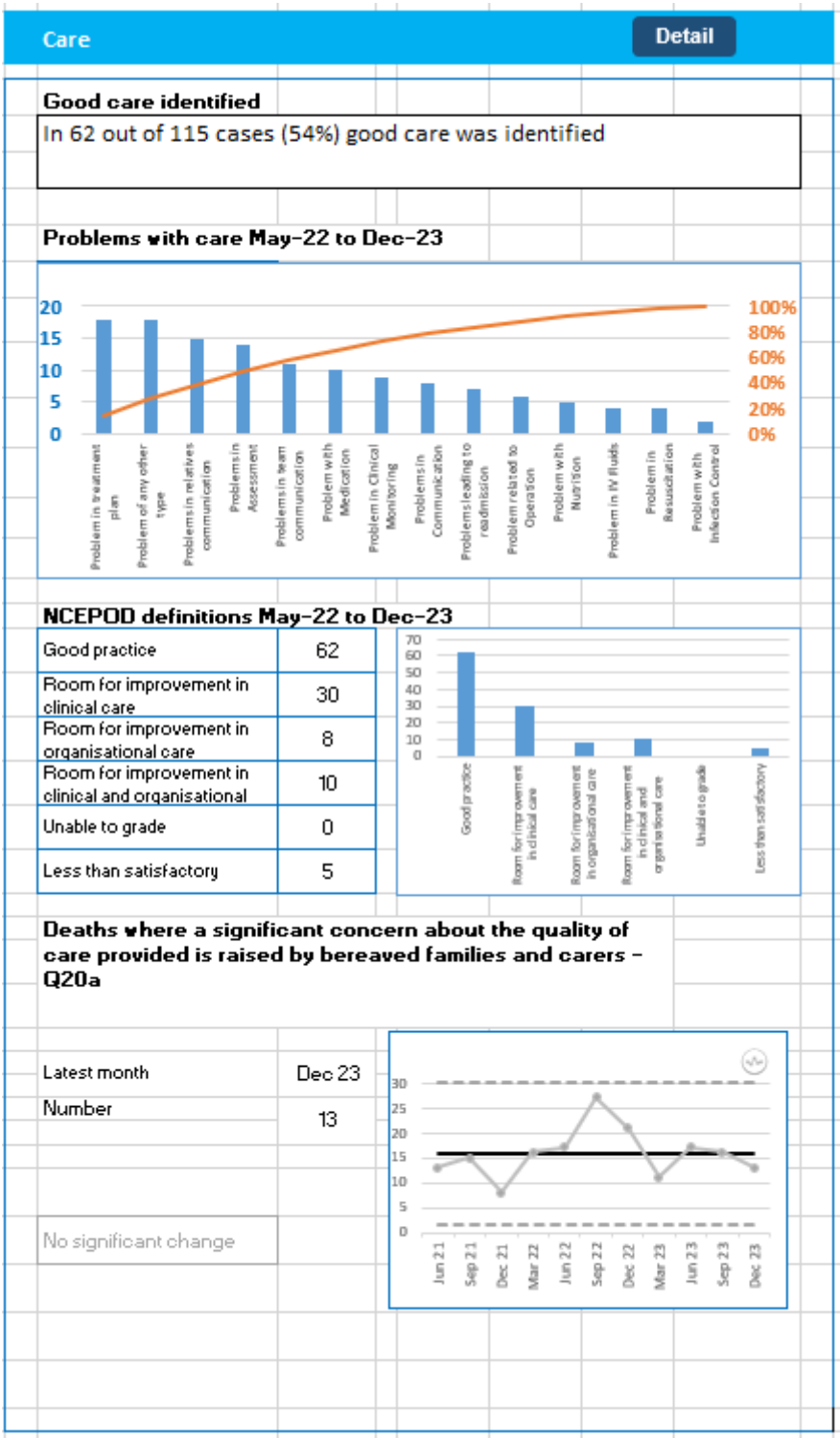
2. Scrutiny to SJR



SUPPLEMENTARY INFORMATION APPENDIX B

APPENDIX B Overview of the Learning from Deaths Dashboard - Context, Scrutiny to SJR, Care (ctd)

3. Care



SUPPLEMENTARY INFORMATION

APPENDIX C

MEDICAL EXAMINER & BEREAVEMENT SERVICE FULL REPORT QUARTER 3 – OCTOBER - DECEMBER 2023

1.0 Introduction

The purpose of this report is to provide the Trust Board with an overview of the number of in-hospital deaths managed by the Medical Examiner & Bereavement Service during quarter 3 (Q3) 2023-24 and the outcome of Medical Examiner reviews, including those with coroner involvement.

2.0 Summary of Hospital Deaths

2.1 There were 542 deaths across both hospital sites during Q3 recorded by the Bereavement and ME service, which was an increase of 107 deaths reported in Q2, and a reduction of 90 deaths from the same period in 2022 (Figure 1). The ME service is required to report this data to NHSE as part of the quarterly return.

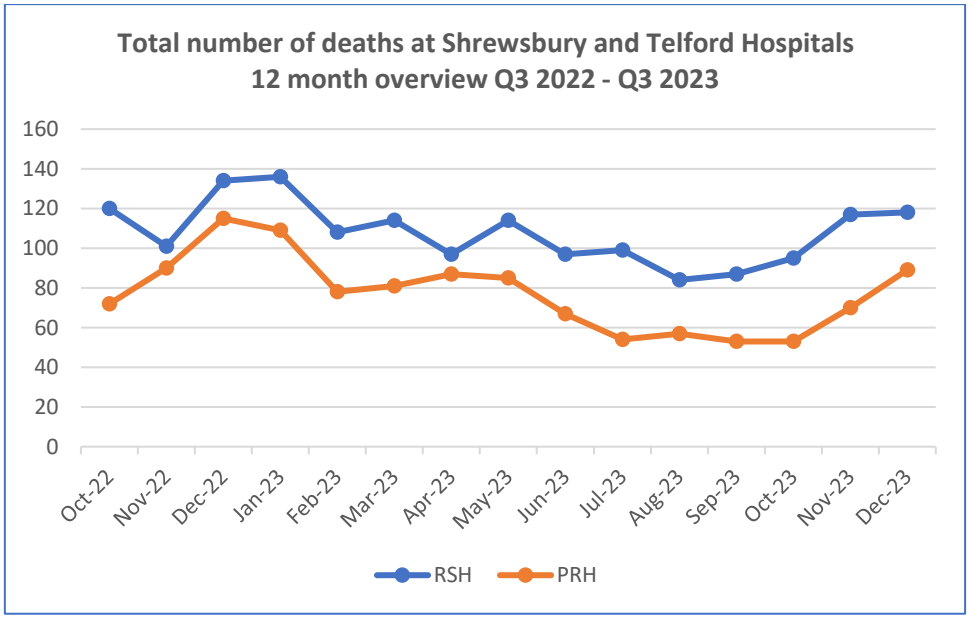


Figure 1 – Total number of deaths at SATH 12-month overview

3.0 Medical Examiner Scrutiny

3.1 Summary

Of the 542 deaths that occurred in Q3, 537 received Medical Examiner scrutiny (Figure 2), 99% of the overall deaths therefore receiving a review. Those cases that did not receive review are cases directly referred to the coroner but not by the ME service. Of these, 97% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. The cases where contact was not made was due to a combination of no next of kin available and relatives not returning calls.

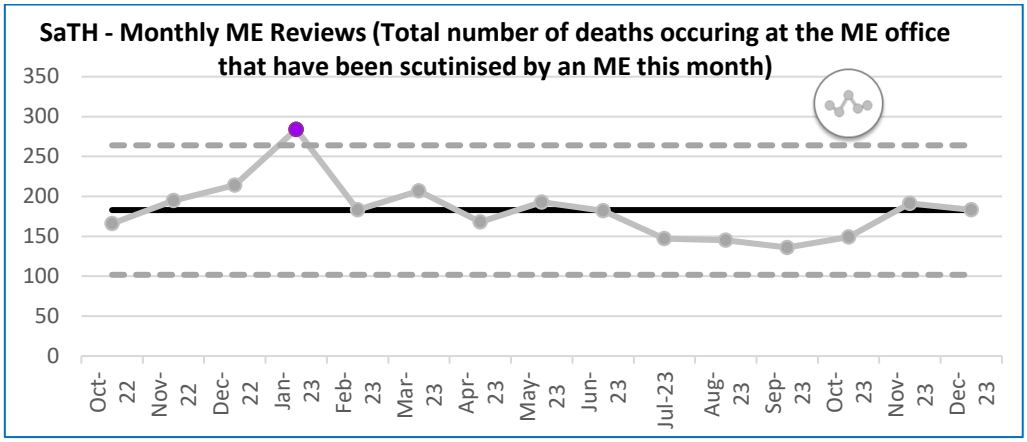


Figure 2– Total Number of Medical Examiner Reviews in 12 month overview

Observations from the above SPC chart show that the Bereavement and ME service can expect to receive an average of 150-200 deaths a month currently across both sites.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 537 deaths reviewed by the ME service, 479 MCCDs were requested following the Medical Examiner review and completed by the treating clinician.

4.2 Of the 479 MCCDs written, 405 of these had no coroner involvement and so the target timeframe for MCCDs with no coroner involvement to be written, is within 3 calendar days. 114 of the MCCDs were not completed within 3 calendar days during Q3. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time.

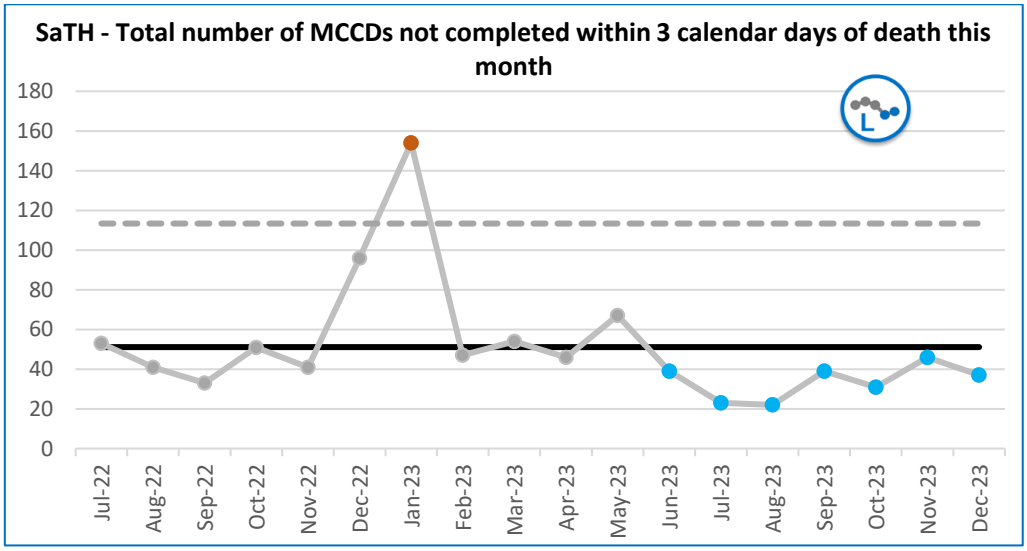


Figure 3 – Number of MCCDs not completed within 3 calendar days of death

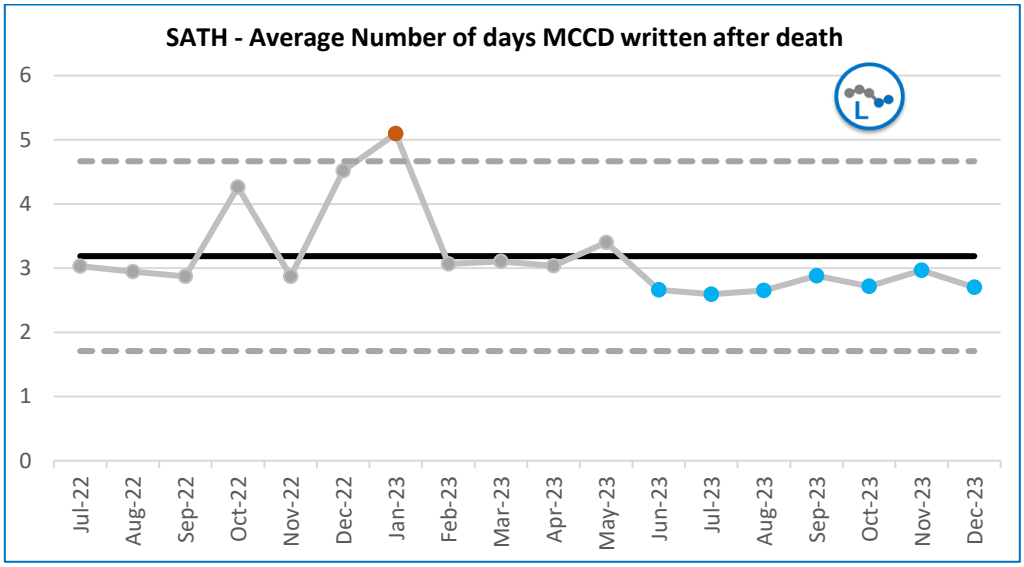


Figure 4 – SaTH Average Number of days MCCD written after death.

Performance with this metric has remained consistent in comparison to Q2, however compliance was challenged during November and experienced some delays due to industrial action.

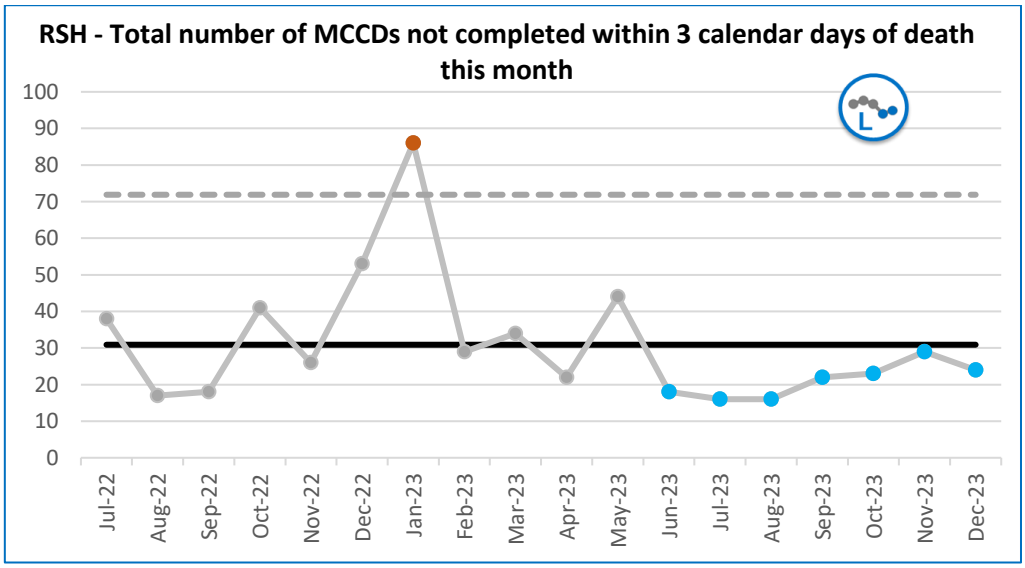


Figure 5 – RSH MCCDs not completed within 3 calendar days

After a renewed focus on ensuring doctors attend promptly to complete MCCDs in October, an improvement in compliance can be seen at PRH. Due to pressures and industrial action later in the quarter, the numbers of MCCDs not completed in 3 calendar days increased.

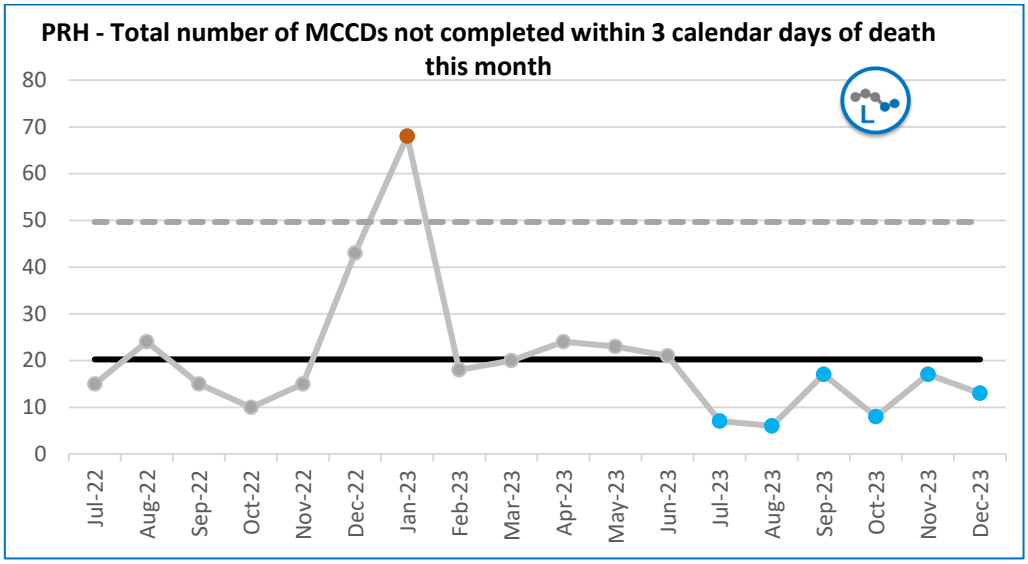


Figure 6 – PRH MCCDs not completed within 3 calendar days

Our performance in respect of meeting 3 calendar days is being monitored by the Regional Medical Examiner. The challenges of completing MCCDs is the point of discussion at Death Management Meetings, with external stakeholders and colleagues from local authority. They are aware of the challenges and are supportive of the significant effort that is put in to ensuring MCCDs are issued as promptly as possible and are assured of the processes in place and the regular communication that occurs between our services.

4.3 MCCDs rejected by Registration Services

Although all adult deaths are reviewed by the Medical Examiner, and a sign off from this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD we have provided. In these cases, the Registrar will either contact the Bereavement Service to discuss the cause of death, or they will refer the death directly to the coroner. Of the 479 MCCDs written and issued, 6 certificates were rejected by Registration Services in Q3. This demonstrates the value the Medical Examiner service is having on ensuring the accuracy of death certification and therefore reducing the upset and inconvenience to bereaved relatives at the point of death registration.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 There were 35 deaths in Q3 (Figure 7) where the Medical Examiner had recommended an SJR.

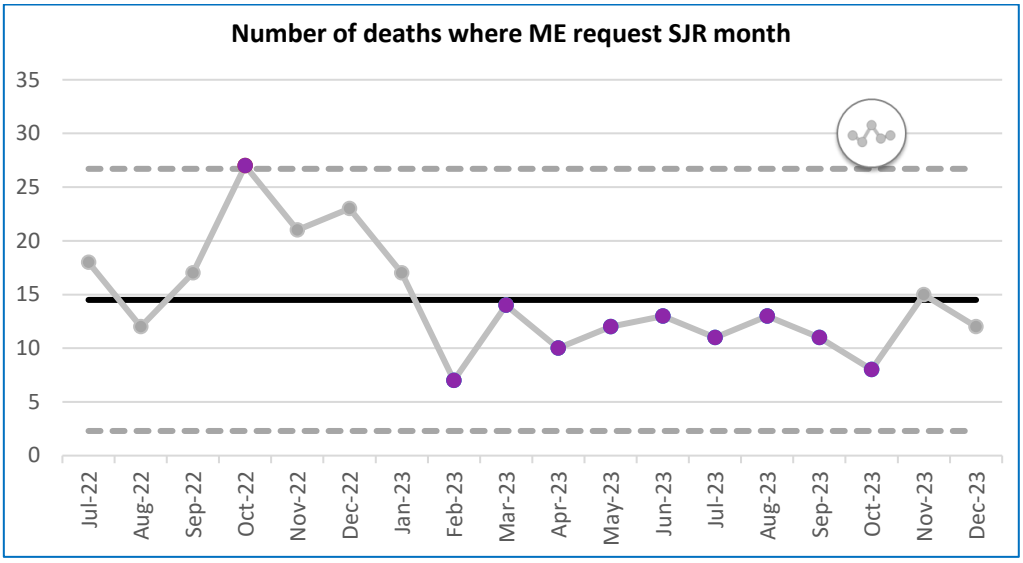


Figure 7 – Number of SJRs recommended following Medical Examiner Review

The SPC chart explains that typically the ME service can recommend on average SJRs in 15 cases a month, but you will see periods where the number recommended have got close to the upper and lower process limits with this correlating with seasonal variance.

Figure 8 below shows the categories for which the Medical Examiner has recommended an SJR review take place. The subject titles are pre-determined options that the Medical Examiner selects from the national exemplar Medical Examiner scrutiny paperwork. The cases that are identified for SJR by the Medical Examiner are then discussed at the weekly mortality triangulation meeting to facilitate SJR review to take place. This information is also submitted to NHSE as part of the quarterly return.

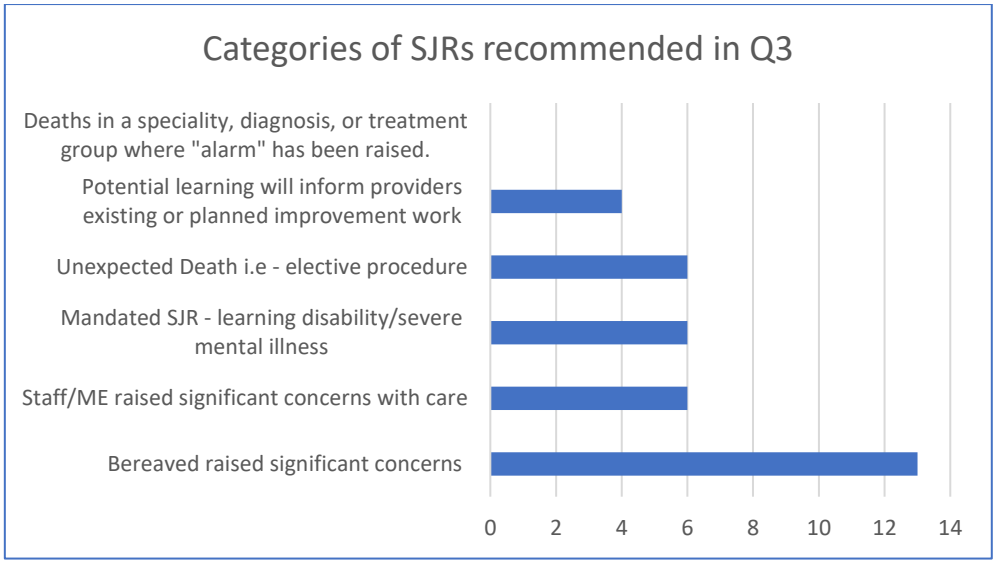


Figure 8 – Categories of SJRs recommended

5.2 Deaths identified by Medical Examiner for potential learning.

Medical Examiners raised potential learning in 87 deaths during Q3, with all these cases being referred to the relevant clinical divisions and specialties for review through their governance processes to ensure learning can be shared. This is a reduction of 4 cases from Q2.

The Medical Examiner service advised the next of kin in 10 cases to contact PALS to raise the concerns that were discussed during the ME interaction.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 118 referrals to the coroner during Q3. This is an increase from what was referred in Q2 by 25 referrals but is in line with the increased number of deaths for this quarter.

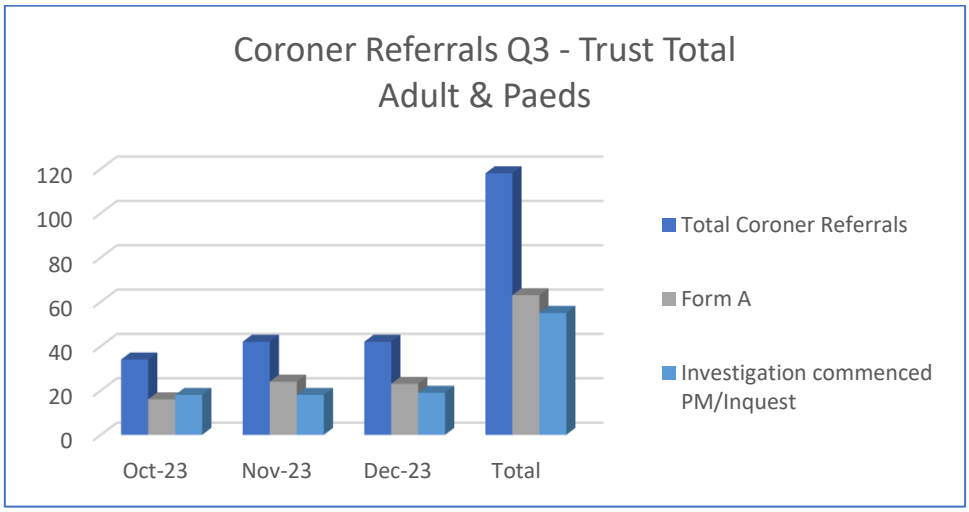


Figure 9 – Coroner referral outcomes 3

Of the 118 referrals for deaths on both hospital sites, the coroner took no further action in 63 of the cases by issuing a Form A and took 55 cases to investigation by either post-mortem or inquest.

7.0 Urgent body release/faith requests

7.1 There were 3 requests for urgent body release for faith purposes in Q3, and these requests were facilitated in the timeframe required during core working hours.

8.0 Service Highlights / Non-Acute Rollout

8.1 The National Medical Examiner shared the draft regulations in December outlining the legislative changes that will come in once the ME service is statutory. These have been shared with Executive colleagues and colleagues in the ICB to keep them appraised of progress with the statutory position. A date for the statutory commencement is yet to be confirmed, but a timetable is expected in early March 2024 and early indication of the reforms to death certification will see significant changes in this process. A meeting with Shropshire Coroner and Registration colleagues is planned for early in Q4 to discuss the statutory position and changes to death certification.

8.2 Despite not receiving confirmation of the commencement date, the project for extending the ME service to the community continues and significant progress with engaging with GP partners and community stakeholders has taken place during Q3 with new partners coming on board and referring deaths to the service.

8.3 A second GP practice and the Severn Hospice are now routinely referring deaths to the ME service for review and plans are in place to commence working with another 6 providers during Q4.

8.6 All GP practices have received instruction from EMIS to switch on permissions for SaTH's ME service to gain access so as and when GP practices come on board, the service is ready to access their EPR. As meetings are held with stakeholders, it is being confirmed that permissions for the ME service to access EMIS web viewer are in place. Training for EMIS has been arranged for the Medical Examiner Officers for Q4.

8.8 The National Medical Examiner is seeking each ME service to submit plans for providing an out of hours service to support cases of urgent body release for faith purposes during weekends and bank holidays. The service requirements for this have altered from being a full 7-day service, to an out of hours service, and so the proposal for an on-call service will support the requirements and the low number of urgent body release requests the service receives. The full proposal for what the ME service can provide will be worked on during Q4.

9.0 Risks

9.1 The ME office accommodation constraints at RSH has been partly resolved during Q3 with a collaborative effort with the PALS & Complaints department with the Complaints team moving out of the main hospital, but remaining on site, making room for the ME service meaning the team can expand as they need to and remain near the wards and therefore the medical staff. Further work in Q4 will take place for the PRH office to allow for more space to accommodate additional staff members.

10.0 Summary

10.1 In summary, our performance of issuing MCCDs within 3 calendar days remains consistent with Q2, the sustained delivery of this KPI is challenged due to the availability of the treating doctor attending to complete death certification. The challenges in our performance for issuing MCCDs does require senior leadership support to ensure there is a clear expectation of clinicians to provide timely support to this process. The ME departments involvement in junior and senior doctor inductions would help support the delivery of this important message.

10.2 The progression of the ME service to ICS stakeholders is progressing at pace and is encouraged by the positive response seen to the communication sent to all GP practices across S, T&W in November, with 25 of the 51 GP practices responding and plans in place to meet with more practices in Q4.

Dr Suresh Ramadoss: Lead Medical Examiner
Lindsay Barker: Medical Examiner and Bereavement Service Manager
January 2024