The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 July 2024

Agenda item	108/24			
Report Title	How We Learn from Deaths and Medical Examiner / Bereavement Service Quarter 4 and Annual Board Summary Assurance Report 01 April 2023 – 31 March 2024			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Dr Roger Slater, Trust Senior Clinical Learning from Deaths Lead, Fiona Richards, Head of Learning from Deaths & Clinical Standards Dr Suresh Ramadoss, Trust Lead Medical Examiner Lindsay Barker, Head of Medical Examiner & Bereavement Services			
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe		Our patients and community		
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register ID:**
Responsive		Our governance	√	ID 435
Well Led	√	Our partners		
Consultation Communication	Trust Learning from Deaths Group, 2nd May 2024 and 6 June 2024 Quality Operational Committee, 18th June 2024 Quality & Safety Assurance Committee 25th June 2024			
Executive summary:	**Learning from Deaths** • The Trust SHMI for October 2023, the latest available data, is 83.93. • The spike in crude mortality within the Emergency Department seen in Q3 / Q4 2022-23, has not reoccurred during 2023-24. • A rise in the crude mortality rate at the Princess Royal Hospital (PRH) December 2023 to March 2024 has been reviewed and is due to the impact of reduced spell activity at PRH following the transfer of renal services, specifically dialysis, to Hollingswood House. • Year-to-date Structured Judgement Review (SJR) completion rate is 18.9% to January 2024. Multi-disciplinary learning through SJRs remains a challenge without regular nursing and Allied Health Professionals (AHP) input into the reviews. • During Q4 2023-24, no deaths within the Trust have been deemed more likely than not to be due to problems in healthcare. **Medical Examiner and Bereavement Service** • There were 2090 deaths reported to the Medical Examiner (ME) Service within the Trust during 2023-24 with 2084 (99%) receiving review. • There have been 567 deaths managed by the Medical Examiner Service during quarter 4 (Q4) 2023-24 a decrease of 59 deaths overall to the comparable quarter in 2022-23. 566 deaths received a review by the ME service.			

	• Performance with MCCD completion deteriorated during Q4 due to the availability of the treating clinician and efficiency of processes within the bereavement team which is being addressed. • Expansion of the ME Service across the Integrated Care System (ICS) has progressed well. By the end of Q4, confirmation of the statutory system had not been received, however this was announced in early April and confirmed the commencement will be 9th September 2024. • By the end of Q4, 13 community providers had started routinely referring their deaths to the ME service including Shropshire Community NHS Trust. • Considerable engagement has been facilitated for community stakeholders across the ICS to understand the impending changes to death certification procedures and to explain the referral process for working with the ME service, whilst encouraging community partners to start referring deaths ahead of the statutory commencement. • Training for the Medical Examiner Officers on EMIS was undertaken during Q4 with full access being granted. • The office accommodation constraints for the Bereavement & ME service at RSH were resolved during Q4 providing additional space for the ME service to facilitate independent review of deaths. • The standard operating procedure for review of paediatric deaths has gone through robust governance processes to ensure an operational process is in place for Q1 of 2024/25. • Delay in the statutory system could see disengagement from community providers and create difficulties with managing the impending demand in a coordinated manner. Work continues with the ICB and GP practices to keep the awareness of the statutory ME programme at the forefront of agendas.
Recommendations for the Board:	The Board is asked to note the report, the issues highlighted, and the progress made for Learning from Deaths and the Medical Examiner & Bereavement Service during Q4 and throughout 2023-24.
Supplementary Information Pack:	Includes Appendix A: Medical Examiner and Bereavement Service Full Q4 and Annual Report and Appendix B: Overview of Learning from Deaths Dashboard;

1.0 Introduction

1.1 Part A of this report provides an overview of the number of in-hospital deaths managed by the Medical Examiner (ME) & Bereavement Service during quarter 4 (Q4) 2023-24, and a summary of the annual report 2023-24 which includes the performance and outcome of ME reviews, including those with coroner involvement. The full Q4 and Annual report 2023-24 for the Medical Examiner and Bereavement Service is available at Appendix A within the Supplementary Information Pack.

1.2 Part B of this report summarises the key issues pertinent to the Learning from Deaths programme of work during quarter 4 (Q4) 2023-24 and a summary of annual performance between 1st April 2023 and 31st March 2024. An overview of the Learning from Deaths Dashboard is at Appendix B within the Supplementary Information Pack.

PART A: MEDICAL EXAMINER & BEREAVEMENT SERVICE KEY ISSUES

2.0 Summary of Hospital Deaths reported to the Medical Examiner Service

2.1 There were 2090 deaths reported to the Medical Examiner Service within the Trust during 2023-24, 567 of these deaths were during Q4. There has been an overall reduction of 192 deaths from the same period in 2022-2023 which reported 2282 deaths for the full year. The ME service has reported this data to NHS England as part of the ME quarterly data return.

3.0 Medical Examiner Scrutiny

3.1 Of the 567 deaths that occurred in Q4, 566 received Medical Examiner scrutiny, 99% of the overall deaths therefore receiving a review. The case where an ME review has not taken place, was due to being directly referred to the coroner but not by the ME service. Of these, 99% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. The 2 cases where contact was not made was due to no next of kin being identified for one case and relatives not returning calls for the other case.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 520 MCCDs written during Q4, 462 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. 154 of the MCCDs were not completed within 3 calendar days during Q4. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time. Our performance of issuing MCCDs within 3 calendar days has deteriorated during the quarter and the sustained delivery of this KPI is challenged in part because of the availability of the treating doctor attending to complete death certification. The internal process of the Bereavement Service is also being reviewed to ensure the service is working in the right way to support timely completion and unnecessary delays are avoided.

4.2 Of the 520 MCCDs written and issued during Q4, 14 certificates were rejected by Registration Services. This quarter has seen the highest rate of MCCD rejections throughout 2023/24, which has provided learning opportunities for the Medical Examiner service. In summary for the 12-month period, the Bereavement Service issued 1889

MCCDs to the Registrar, of which they rejected 34 which were then forwarded to the coroner service, at their discretion.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 There were 40 deaths where the Medical Examiner recommended an SJR during Q4. Further analysis of the reasons for why an SJR was recommended is covered in the full report which is available in the supplementary information pack. Of the 2084 deaths that received ME review during 2023/24, the ME recommended SJRs in 145 cases, resulting in 6% of the overall deaths being recommended for a further review by the Trust following proportionate scrutiny from the Medical Examiner service.

5.2 The Medical Examiner service raised potential learning in 97 cases during Q4 & 354 over the 12-month period. All these cases were referred to the relevant clinical divisions and specialties for review through their governance processes.

5.3 During discussions between the next of kin and the Medical Examiner throughout 2023/24, 47 families were advised to contact PALS to raise concerns that were discussed during their interaction with the ME.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 95 referrals to the coroner during Q4. This is a reduction from what was referred in Q3 by 23 referrals. Of the 95 referrals made for deaths on both hospital sites, the coroner took no further action in 59 of the cases by issuing a Form A and took 36 cases to investigation by authorising either a post-mortem or inquest. Reviewing the referral activity over the 12-month period, 411 referrals were made, of which the coroner took no further action in 236 of the deaths and took 167 cases for investigation.

7.0 Service Highlights

7.1 The Department of Health and Social Care has now confirmed the date for statutory commencement is the 9th September 2024.

7.2 The project for extending the ME service to the community continued at pace throughout 2023/24 as the statutory footing was expected by April 2024. This has ensured the ME service is in a good position for the statutory commencement in the Autumn.

Information sharing events were held with GP practices across the ICS throughout Q4, to inform them of the referral process and changes to the death certification regulations. Positive engagement was achieved and saw 32 GP practices attending the three sessions that were held. These GP practices are now fully aware of the process and equipped to start referring their deaths to the ME service and are being encouraged to do so ahead of the statutory commencement.

A full update has been provided to the ICB with progress in engaging GP practices across the system.

7.3 Further work on the out of hours ME service has been undertaken with discussions held with all Medical Examiners on their willingness to take part in an out of hours on call system. This will be in place to prevent delays in releasing bodies for faith purposes and

ensure a proposed cause of death in organ donation cases is approved by an independent medical examiner, before obtaining coroner approval for organ retrieval.

8.0 Summary

8.1 The Bereavement & Medical Examiner Service has continued to provide an efficient, effective, and supportive service to the bereaved during 2023/24.

8.2 Performance of issuing MCCDs within three calendar days has deteriorated during Q4 and the sustained delivery of this KPI is challenged in part because of the availability of the treating doctor attending to complete death certification. The internal process of the Bereavement Service is also being reviewed to ensure the service is working in the right way to support timely completion and unnecessary delays are avoided. The production of the monthly performance dashboard provides the required analysis to support the ongoing work of reviewing the department's processes and therefore the delivery of this key target.

8.3 In the statutory ME system, the changes to death certification regulations will see the 5-day target for death registration starting from the day the registrar receives an approved MCCD from the ME service, and not from the date of death. However, it was considered prudent to keep the KPI of three calendar days for MCCD completion as this supports the bereaved with prompt death registration and supports mortuary capacity constraints. Support by Senior Trust Leadership has been received with the Bereavement & ME Service being included in doctor induction to deliver the message on the importance of timely death certification. This will be progressed during quarter one of 2024/25.

8.4 The expansion of the service to ICS stakeholders has made considerable progress over the course of 2023/24 and has engaged with a substantial number of community partners during this time, with them now referring their deaths into the service for ME review. Further work continues with the ICB in agreeing a process for how the ME service will escalate concerns and provide feedback from the reviews of community cases.

Dr Suresh Ramadoss, Trust Lead Medical Examiner
Lindsay Barker, Head of Medical Examiner and Bereavement Services
April 2024

PART B: LEARNING FROM DEATHS KEY ISSUES

9.0 Summary of Hospital Deaths: Crude Mortality

9.1 Of the 567 deaths managed by the Medical Examiner Service within the Trust during Q4 2023-24, 463 occurred as an inpatient and 104 occurred within the emergency department (ED). This figure compares to 626 deaths in the comparative quarter during 2022-23, representing an overall decrease of 59 deaths.

The spike in crude mortality across the Trust at the end of Q3 into Q4 2022-23 in particular within the ED, has not been repeated during 2023-24. Whilst there has been a slight increase in the number of deaths at the end of Q3 and into Q4 during the current year this is in line with seasonal variation. The increase did not reach the peak seen in 2022-23 and crude mortality for the Trust including both inpatient and ED deaths now demonstrates common cause variation as seen in chart 1 below.

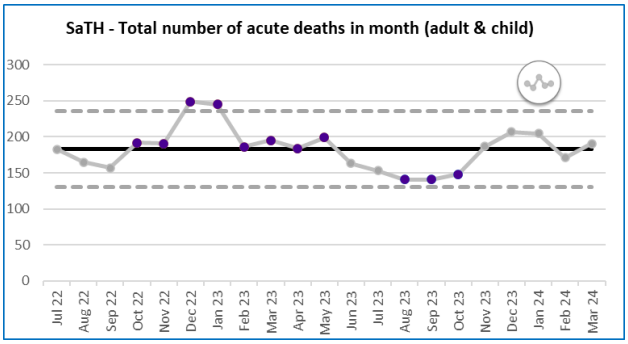

Chart 1 Trust Crude Mortality

Inpatient and ED crude mortality to Q4 2023-24 is shown at Charts 2 and 3 below demonstrating common cause variation, with charts 4 and 5 showing inpatient and ED mortality as a percentage of the overall number of deaths within the Trust.

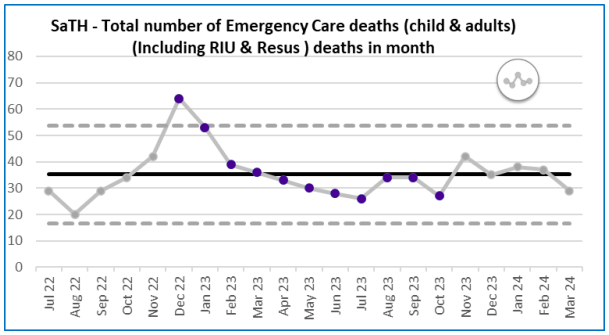

Chart 2 ED Crude Mortality

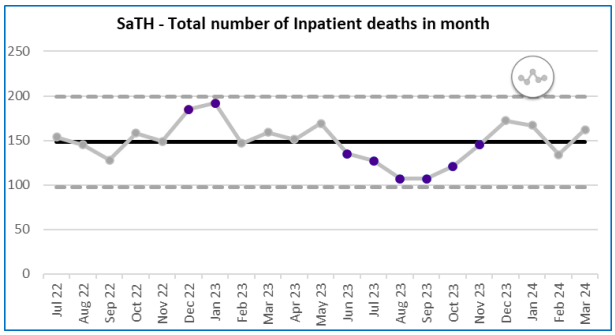

Chart 3 Inpatient Crude Mortality

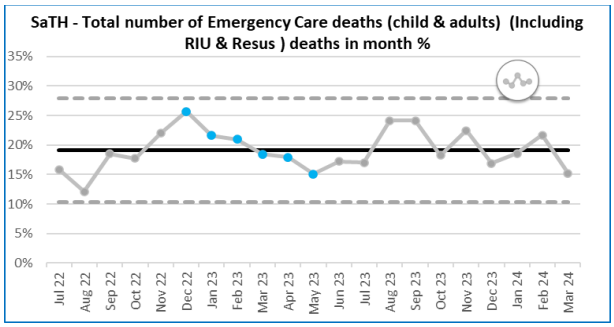

Chart 4 ED Mortality % All Deaths

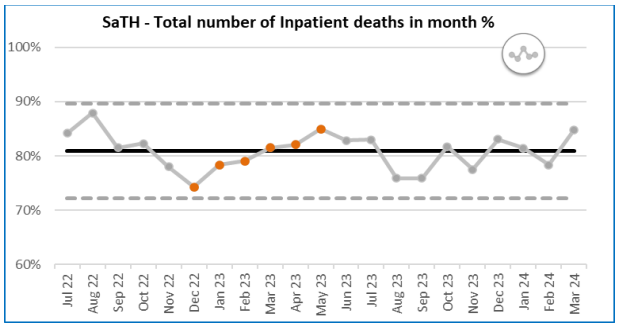

Chart 5 Inpatient Mortality % All Deaths

9.2 Of the 567 deaths in Q4 2023-24, 241 were observed at the Princess Royal Hospital (PRH) and 326 at the Royal Shrewsbury Hospital (RSH). A breakdown of mortality data across both hospital sites by month is provided at charts 6 and 7 below. Common cause variation is currently demonstrated after the overall increase in deaths seen across the Trust at the end of Q3 into Q4 2022-23.

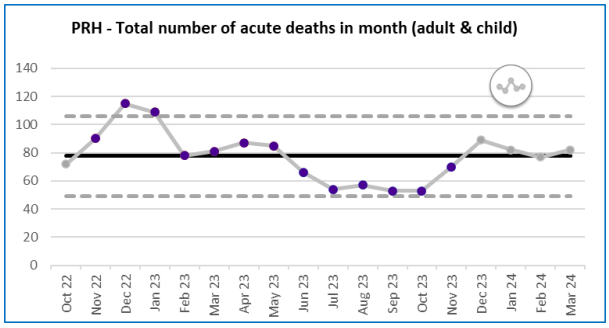

Chart 6 PRH Crude Mortality

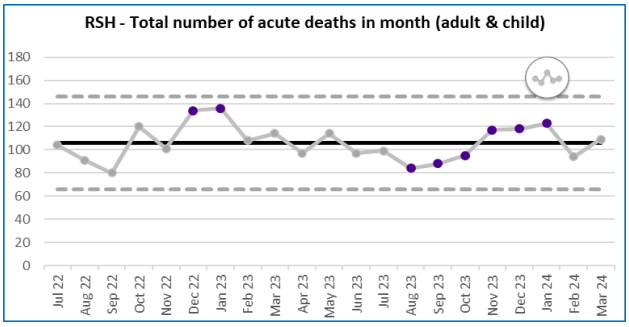

Chart 7 RSH Crude Mortality

9.3 Divisional mortality data remains consistent across the Trust with approximately 80% of deaths observed within the Medicine and Emergency Care (MEC) Division, and 20% observed within the Surgery and Cancer Care Division (SACC), with less than 1% observed within the Women and Childrens (W&C) Division. Common cause variation is demonstrated within the charts 8 to 10 below.

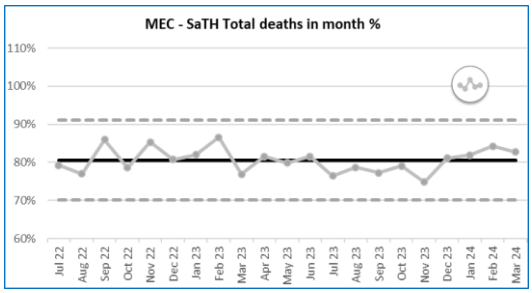

Chart 8 MEC % All Deaths

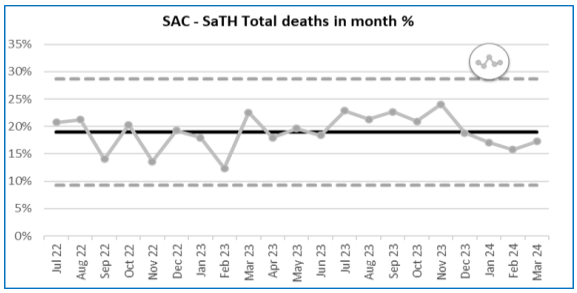

Chart 9 SACC % All Deaths

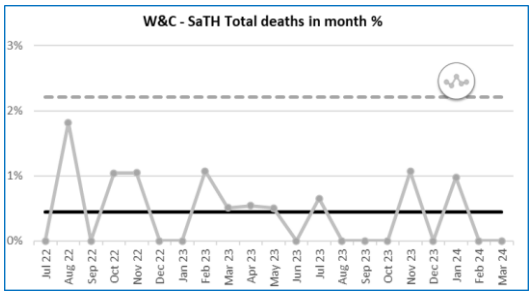

Chart 10 W&C % All Deaths

9.4 Crude Mortality Rate

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and expresses this as a proportion of the number of people admitted for care in that hospital over the same period, without incorporating any risk adjustment. The crude mortality rate can then be articulated as the number of deaths for every 100 patients admitted. A review of crude mortality is therefore useful to provide context especially with regards to trends. Chart 11 (source CHKS) shows the Trust's crude mortality rate between April 2022 and March 2024, compared to the CHKS Peer Group. The CHKS Peer Group comprises of acute hospital trusts which have been identified as the most similar to SaTH.

Chart 11 Crude Mortality Rate

There is evidence of an increase in the overall crude mortality rate within the Trust since December 2023. This increase however is in line with the CHKS Peer Group, although the rise at PRH is higher than at RSH and it continues to March 2024, the latest available

period at the time of finalising this report. The overall crude mortality rate for RSH and PRH over the last two years are shown at Chart 12 below.

Chart 12 Crude Mortality Rate By Site

A review of the increase in crude mortality rate at PRH has been undertaken by CHKS and a decrease in the number of patient spells at PRH from December 2023 of around 1000 spells per month was identified. At the same time, there was a corresponding increase in spells at a new site – Hollinswood House. This is due to the relocation of Telford renal services from PRH. The spells at Hollinswood House are all dialysis patients under specialty 361 – Renal Medicine.

Chart 13 below shows the total spells for specialty 361, illustrating the clear shift in activity between sites. From December 2023, there were on average 25 spells per month remaining at PRH for specialty 361.

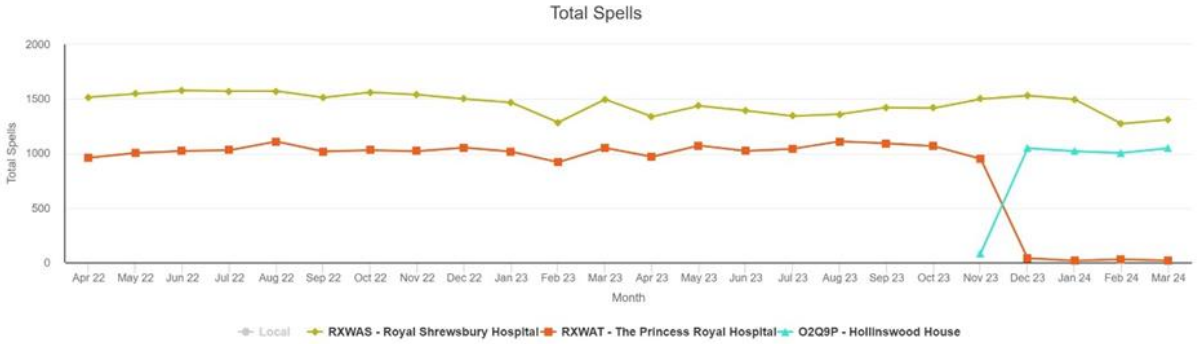

Chart 13 Total Spells Specialty 361

This fall in the number of spells at PRH from December reduces the denominator for the crude mortality. However, because these patients are very unlikely to die in hospital during these spells, the numerator for the indicator (the number of deaths) remains the same for PRH. Therefore, the crude mortality rate increases.

A slight rise in the Trust's non-elective crude mortality rate trend over the winter period is broadly in line with the CHKS Peer Group as seen at chart 14 with an increase noted at both sites as per chart 15. The non-elective mortality rate is unaffected by the transfer of renal services to Hollinswood House as the renal service is for elective patients. The spells in question are planned admissions.

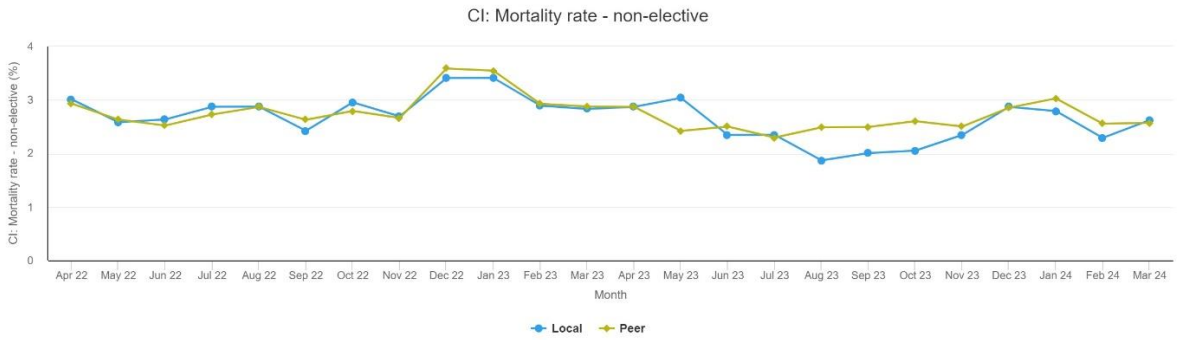

Chart 14 Non-Elective Crude Mortality rate

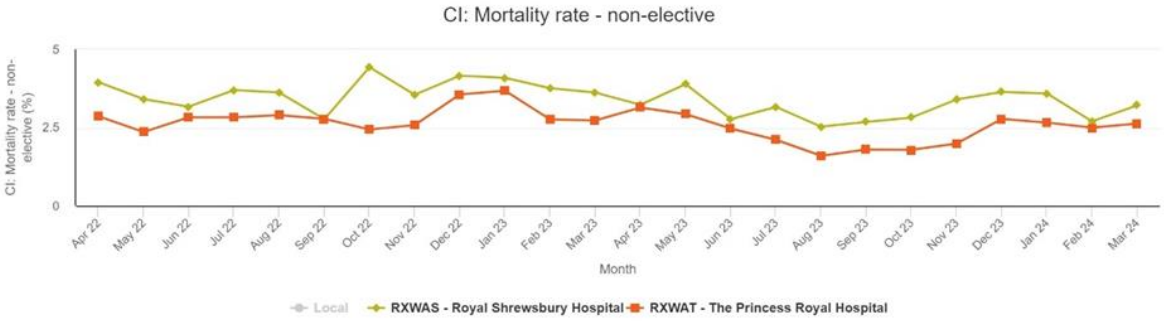

Chart 15 Non-Elective Rate By Site

10.0 Learning from Deaths Dashboard

10.1 A high level visual overview of the dashboard is provided at Appendix B in the Supplementary Information Pack highlighting key metrics relating to:

- Context around Learning from Deaths including the latest available data for non-risk adjusted (crude mortality rate) and risk adjusted mortality (SHMI).
- Medical Examiner Scrutiny to SJR, including mortality screening for Q4 2023-24.
- High level details relating to care for Q4 2023-24.

10.2 Summary Hospital-level Mortality Indicator (SHMI):

SHMI is a risk adjusted index that includes deaths in hospital as well as those which occur within 30 days of discharge. The Trust's SHMI and the trend for observed versus expected deaths is monitored through the Learning from Deaths Dashboard as a monthly standing agenda item.

The Trust SHMI for October 2023, which is the latest available data, is 83.93. This is within the expected range and is favourable to the CHKS Peer Group average as seen at chart 16. The 12-month SHMI rolling trend, is again favourable to the CHKS Peer Group and shows a downward trend as per chart 17. A decrease in observed versus expected deaths between July and September 2023 is driving the low SHMI in September as can be seen at chart 18. The higher expected deaths may indicate that there have been more complex patients admitted to hospital within the period.

Chart 16: SHMI trend compared to Peer

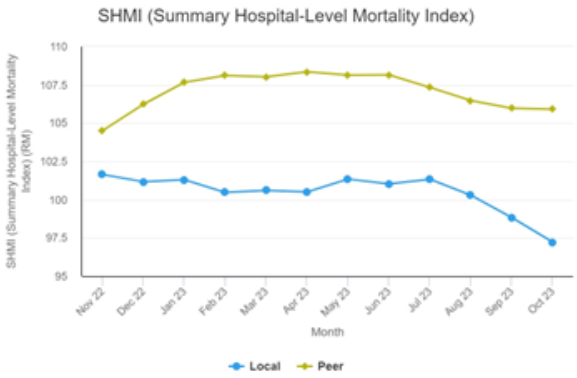

Chart 17: SHMI Rolling Month Trend

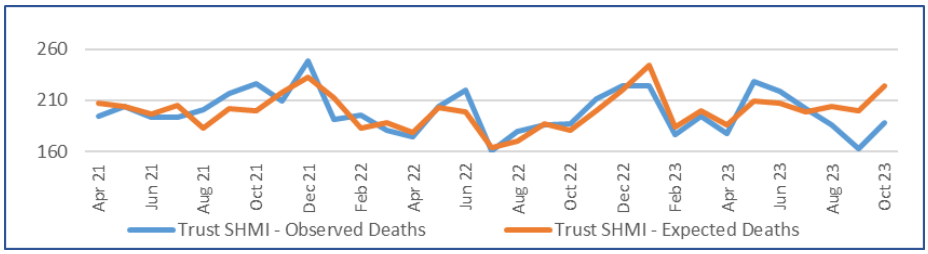

Chart 18: SHMI Observed vs Expected Deaths

The latest available SHMI data from CHKS, shows septicaemia to be the primary diagnosis condition with the highest number of "excess" deaths (more deaths than expected by the SHMI model). The index for this condition had increased from the previous period and was higher than the peer average. The Learning from Deaths team continues to work collaboratively with the Deteriorating Patient Leads to support ongoing improvement work relating to the deteriorating patient and specifically to sepsis.

The Q3 2023-24 iteration of this report detailed an assurance review that was underway to review care of patients who died with a primary diagnosis code of myocardial infarction. This has been completed in collaboration with a Consultant Cardiologist. No patient safety incidents were identified and learning relates to the use of ReSPECT forms and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, End-of-Life Care and specifically the use of syringe drivers, and team communication especially when liaising with other acute trusts.

10.3 Deaths in low mortality condition groups:

Between October and December 2023 there has been 1 death identified within the Trust where the primary diagnosis condition is considered low risk. Deaths in this category are reviewed on an individual basis.

10.4 Wider metrics relevant to mortality across the Trust include hospital occupancy and length of stay. These are displayed on the overview of the Learning from Deaths Dashboard as seen at Appendix B.

10.5 Medical Examiner Scrutiny:

A summary of Medical Examiner Service activity is detailed in Part A and Appendix A of this report.

10.6 Mortality Screening:

Clinical colleagues are provided with the opportunity to complete online mortality screening for cases which have not been flagged for SJR through another route, including the Medical Examiner and the Trust Mortality Triangulation Group (MTG). During Q4 2023-24, 211 online mortality screenings were received of which 87 were completed for deaths within the quarter. 25% of screenings were completed less than 4 weeks after the death of the patient and a further 40% were completed between 5 and 8 weeks after the death. Of the 242 screenings, 11 were classed as 'positive', which means that learning was identified, which also includes positive feedback. All positive screening cases are subsequently discussed at the weekly MTG meeting where the most appropriate method to review or share the identified learning is confirmed. This may result in an SJR being raised, learning being shared with the appropriate clinical teams, or it may be identified that there is another review already underway for the same issues, for example a Formal Complaint or Datix investigation. In these circumstances, a review of care is not usually duplicated.

10.7 Structured Judgement Reviews:

During the period of intensive support provided by NHS England to develop the Trust Learning from Deaths agenda, the 'Better Tomorrow' Leads recommended that 15% of all adult deaths across the Trust should receive an SJR to ensure sufficient information is available to identify themes and trends for learning. Whilst this is not a nationally mandated target, it has been adopted within SaTH as 'best practice' in conjunction with the aim to complete SJRs within 8 weeks of the patient's death. Identifying learning promptly following a patient's death helps to ensure it is both relevant and actionable and can appropriately inform wider improvement initiatives within the Trust. The ability to complete SJRs within 8-weeks of the patients death is however negatively impacted by any delays experienced within the Clinical Coding of deceased records and the availability of SJR reviewers during periods of leave, including sickness and holidays.

To improve SJR completion rates within the Trust, a local target of completing 30 SJRs per month was introduced last year. Following the recruitment of a pool of SJR reviewers and the introduction of a new process within the Learning from Deaths team to streamline notes management and the allocation of reviews, this target has been achieved and sustained since May 2023 as is shown at chart 19. As a result of the increased SJR completion per month, the Trust has demonstrated month on month compliancy with the target to review 15% of all adult deaths achieved since June 2023. This is demonstrated within the Learning from Deaths Dashboard SJR Overview (% of total deaths) at Appendix B. The overall percentage of SJR completion for deaths within the year to date to January 2024 is 18.9% of which 80% were completed within 8 weeks of the patient's death.

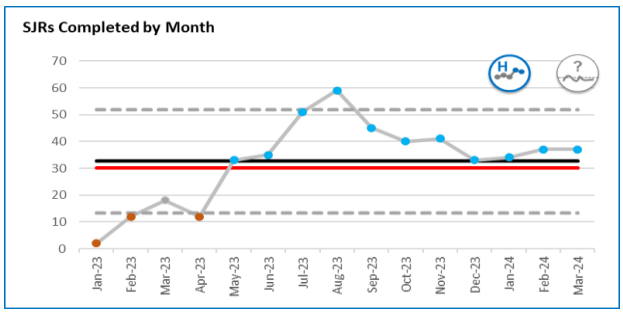

Chart 19 SJRs Completed By Month

Compliancy with both the number of SJRs completed each month and the percentage of deaths within each month that have received an SJR is monitored as a standing agenda item on the monthly Learning from Deaths Group through the presentation of the Trust Learning from Deaths Dashboard and the Trust Integrated Performance Report (IPR).

When reporting on performance within the Learning from Deaths Dashboard relating to the percentage of deaths within a given month that have had an SJR completed as seen at Appendix B, there will be a delay in the latest available data seen. This delay reflects the 8-week period for SJR completion from the date the patient died and the subsequent timeframe required for construction of the Learning from Deaths Dashboard in collaboration with the Performance Team.

Utilising a multi-disciplinary approach to SJR completion maximises the learning that can be identified and is the approach encouraged by NHSE. Within SaTH the completion of SJRs is currently limited to medical colleagues with allocated Programmed Activity (PA) time, and senior nurse support on an ad hoc / temporary staffing basis. Support for specialist input for the review of patients with a learning disability or serious mental illness is provided by the relevant specialist nurses. To maximise the learning opportunities to inform quality improvement initiatives, sustained and regular support from the wider clinical teams and in particular, senior nursing colleagues is essential or there is a risk that the learning opportunities arising from SJRs may be less impactful. At the present time, there have been no available solutions to this identified.

10.8 Care:

An overall care rating of good or excellent was provided in 60% of the SJRs completed during Q4 2023-24. An overall assessment rating of poor was identified in just under 16% of cases, with the remainder being rated as adequate. An SJR datix is required for any case where a rating of poor or very poor is given. This ensures that the care provided is reviewed by divisional teams in addition to the SJR reviewer and is then discussed at the Trust Incident Response Oversight Group - IROG (formerly known as the Trust Rapid Review Group) to determine level of harm and any actions required to address learning identified.

Of the 108 SJRs completed during Q4 2023-24, 42 met the criteria for submission of an SJR datix based on identification of an unexpected death, poor / very poor care, Hogan score of preventability greater than 50:50 or above, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading less than satisfactory, any problem in care where potential harm was identified or any case where the reviewer did not feel able to grade the care. An SJR datix is not a patient safety incident datix, although may be converted to this and be reportable to the National Reporting and Learning System (NRLS) once the case has progressed through the Trust IROG forum where level of harm is agreed. Poor compliancy with SJR datix submission was reported in the Q3 2023-24 iteration of this report (an SJR datix had been submitted appropriately in only 52% of cases). Following targeted improvement work and a review of the process a 90% compliancy rate for SJR datix reporting has been achieved for SJRs completed during Q4.

10.9 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ratings:

An NCEPOD rating of ‘Good’ was given in 42.6% of the SJRs completed in Q4 2023-24, with 33% identifying ‘Room for Improvement in Clinical care’, 11.1% identifying room for

improvement in organisational care, 8.3% identifying 'Room for improvement in clinical and organisational care' and 7.4% identifying an NCEPOD rating of 'Less than satisfactory'.

10.10 Deaths where a significant concern about the quality of care provided is raised by bereaved families or carers:

Bereaved families and carers have the opportunity to discuss the care provided to their loved ones during Medical Examiner Scrutiny of each case. Responding to feedback given is a vital part of the Learning from Deaths process within the Trust. During Q4 2023-24, significant concerns were raised by the bereaved during Medical Examiner Scrutiny in 13 cases where the patient died. Two additional cases were initially recorded under this category but identified as errors in documentation.

At the time of writing this report, formal complaints have been raised in 2 of the cases within Q4 and Structured Judgement Reviews (SJRs) completed for 6 of these cases, with 4 SJRs outstanding. One Patient Safety Incident Investigation (PSSI) has been commissioned on the basis of a potentially avoidable death. Significant concerns raised by bereaved families or carers for patients who died during Q4 relate to delays in transfer of patients from ED to the wards and to the surgical team at RSH, patient falls, communication from staff including diagnoses and investigations, management of leg ulcers, initiation of treatment including antibiotics, concern around possible failed discharges and discharge whilst still in pain.

11.0 Learning to Improvement

11.1 Positive learning themes identified during Q4 2023-24 through the completion of SJRs as well as the wider Learning from Deaths processes including the weekly MTG relate to:

- Evidence of good documentation of care, completed by various members of the multidisciplinary team, including nursing, medical and physiotherapy teams.
- Clear and effective communication with patient and next of kin, regarding care plan and patient wishes. Emphasis on frequent and compassionate engagement.
- Evidence of collaborative care between clinical teams. Timely referrals to relevant specialities within SaTH and external specialist centres.
- Demonstrable multidisciplinary reviews and investigations with comprehensive patient assessments and care escalated accordingly.
- ReSPECT and End of Life (EoL) Care addressed promptly, patient comfort and dignity prioritised. Appropriate recognition of End-of-Life stage and pathway initiated in a timely manner. Patient preferences prioritised.

Learning from excellence is celebrated and promoted through the wider Learning from Deaths agenda including the Trust Learning from Deaths Group and Divisional Morbidity and Mortality or Governance meetings. Positive feedback and 'Learning from Excellence' certificates are sent to individual clinicians and clinical teams, many of which are hand delivered.

11.2 SJR reviewers have the opportunity to categorise the learning identified within SJRs into various 'Problem in Care' headings. These are:

- Problem leading to admission or readmission
- Problem in initial assessment, investigation or diagnosis
- Problem related to initial or ongoing treatment and management plan

- Problem in clinical monitoring
- Problem related to any invasive procedure, including surgical operation in theatre setting, or intervention requiring anaesthetic
- Problem in resuscitation following a cardiac or respiratory arrest, including 'Do Not Resuscitate' decisions
- Problem with medication
- Problem with IV fluids/electrolytes/oxygen
- Problem with nutrition
- Problem with infection control
- Problem in communication with the patient
- Problem in communication among teams
- Problem of any other type

11.3 The top 3 'problems in care' identified within the 108 SJRs completed during Q4 2023-24 remain consistent with Q3 2023-24:

1. Problem in initial assessment, investigation or diagnosis (25 cases). Specific learning relates to:
    - Delayed or missed reviews of clinical investigations or monitoring undertaken including diagnostic imaging, blood results and NEWS resulting in subsequent delayed escalation and management.
    - Appropriate use of continuous cardiac monitoring.
    - Lack of timely recognition and appropriate treatment of sepsis, including consideration of atypical presentations.
    - Assessment and recording of new confusion within National Early Warning Score (NEWS).
    - Delayed or missed opportunities for referral to other specialities and support services, such as SALT, Safeguarding, Nutritionist and Dementia Team.
    - Lack of timely senior ED / specialty review, ED or medical clerking or input with care planning.
    - 'Over-investigation' of patients leading to potential harm as well as inappropriate use of resources.
    - Issues around appropriate assessment, completion and understanding of Mental Capacity Act (MCA) and Best Interests (BI) forms including during the completion of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms.

2. Problems of any other type (15 cases). Specific learning relates to:
    - Delays within the Emergency Department (ED) including ambulance offload delays and patients experiencing long waits for admission to a ward. Ambulance offload delays of over 6 hours are reported via a Patient Safety Datix and the care provided reviewed to identify the impact of the delay on the safety of the patient.
    - Senior medical decision making and treatment planning – burden of treatment versus best outcomes for the patient / provision of holistic care not evidenced in notes. Care provision not patient centred.
    - Multiple ward transfers and use of day ward where medical care not optimal.
    - Safeguarding – delay in referral.
    - End-of-life care – recognition of dying and early initiation of Swan care plan, use of anticipatory medications.

- Delays in verification of death —this has been a consistent theme during 2023-24 and in particular following cardiac arrests. Following liaison with the Resuscitation team, it has been agreed that the on-call Resuscitation team attending the cardiac arrest will confirm which clinician is responsible for verifying the death as part of the post arrest handover. This plan has a positive impact and a reduction in this problem has subsequently been noted.

3. Problems in team communication (14 cases). Specific learning relates to:
    - Lack of appropriate MDT discussion for complex patient.
    - Delay in medical reviews and issues with incomplete medical clerking and examination.
    - Documentation issues including completion of nursing charts for example, nutrition charts.
    - Documentation issues around involvement of tertiary centres.
    - Disagreements between clinical specialties.
    - Conflicting senior documentation resulting in a lack of clarity about the plan of care.
    - Poor access for PRH ward teams to Urology.
    - Lack of guideline for acute delirium.
    - Use of colloquial language rather than clear medical terminology.

11.4 Other key themes of learning identified through SJRs completed during Q4 2023-24 as well as the wider Learning from Deaths processes including the weekly MTG group are consistent with previous quarters and relate to:

- Medication issues including delayed prescription of drugs, poor documentation of allergies leading to prescription errors, omission of drugs and antibiotics including time-critical medications, concerns raised relating to the use of sedation, opiate overdose, missed oxygen prescription and stock level issues. The Learning from Deaths team work closely with the Medicines Safety Officer (MSO) to share learning to support quality improvement initiatives across the Trust.
- Management of fluid balance and electrolyte imbalance including completion of fluid balance charts and maintenance fluids not given in line with Trust policy. Learning identified is referred to the Trust Fluid Balance Specialist Nurse to support the ongoing programme of improvement that is already underway within the Trust.
- Readmission and discharge issues including discharge planning and failed discharge.
- Issues concerning the provision of EoL care include communication with the family and multidisciplinary team, lack of clear documentation of ceiling of care, delayed recognition of active dying including failure to initiate Swan care pathway. The Learning from Deaths team continues to work closely with the Palliative and End-of-Life Care (PEoLC) team sharing identified learning appropriately. This is subsequently fed into the system wide steering group and used to support quality improvement initiatives both within the Trust and the wider Integrated Care System (ICS).

11.5 The Learning from Deaths team work closely with healthcare professionals across the organisation and the wider Integrated Care System for example, the Integrated Care Board (ICB), West Midlands Ambulance Service (WMAS), Shropshire Community Trust (ShropCom) and other acute hospital trusts, to appropriately share identified learning and positively influence quality improvement initiatives for the communities we serve.

12.0 Maternal Mortality

12.1 There were no direct, indirect or coincidental maternal deaths reported by the Trust within Q4 or during the full year 2023-24.

13.0 Perinatal Mortality

13.1 During the full year 2023-24, there were 5 neonatal deaths where the baby was born over 22 weeks gestation and 10 stillbirths within the Trust which fall outside of the remit of the Medical Examiner Service. Of these, 3 stillbirths and 1 early neonatal death occurred within Q4.

13.2 At the time of writing this report, PMRT had been completed for 1 stillbirth which occurred during Q4 2023-24. The care was graded B, which means no issues were identified which would have impacted on the outcome.

13.3 During Q4, there was 1 late fetal loss reported to MBRRACE-UK meeting the criteria for review using the Perinatal Mortality Review Tool (PMRT) and 1 early fetal loss which did not meet the criteria for referral to MBRRACE-UK.

13.4 The MBRRACE-UK Perinatal Mortality Report: 2022 Births within the Shrewsbury and Telford Hospital NHS Trust, has been received by the Trust. This continues to show higher than average neonatal mortality compared to similar Trusts and Health Boards. This report is being reviewed by the Maternity Governance team in the first instance. A more detailed response will be included in future iterations of this report.

13.5 The final report following the invited external expert review completed in Q3 2023-24 in relation to the 'above average' mortality within SaTH highlighted in the 'Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries' (MBBRACE-UK) reports for 2021 and 2022, has not yet been received by the Trust. The action plan arising from the initial findings was presented to the Quality Operational Committee in April 2024 and progress will be monitored through Divisional Performance Review Meetings (PRMs). Once received by the Trust, the recommendations from the final report will be included in the following iteration of this report.

14.0 Paediatric Mortality

14.1 During 2023-24, a total of 13 paediatric deaths were managed by the Medical Examiner Service within SaTH, two of which occurred within Q4. Both of these deaths occurred in the ED and will be reviewed through the Child Death Overview Panel (CDOP) process to identify learning. No serious incidents, or PSIRF Learning Responses have been commissioned within the Trust for either of these cases.

15.0 Deaths deemed more likely than not due to problems in healthcare

15.1 A potentially avoidable death is defined within the National Quality Board (2017) guidance as any death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare. The methodology used to investigate potentially avoidable deaths in the Trust was, to the end of November 2023, the Serious Incident Framework (SIF). From December 2023, this has been replaced with the Patient Safety Incident Response Framework and deaths that are considered at the outset to have been

potentially due to problems in healthcare, will be investigated as a Patient Safety Incident Investigation (PSII).

15.2 On completion of an investigation, SIs or PSIIs are presented to the Trust Review Actions and Learning from Incidents Group (RALIG), chaired by the Executive Medical Director. Deaths judged more likely than not to have been due to problems in healthcare and therefore potentially avoidable are reported to the Board of Directors.

15.3 During Q4 2023-24, there have been no deaths presented to RALIG where the death was deemed more likely than not due to problems in healthcare and therefore considered potentially avoidable.

16.0 Deaths of patients with a confirmed Learning Disability and Autism

16.1 Research has shown that people with a learning disability (LD) or autism die earlier in their lives and do not receive the same quality of care as people who do not have an LD or autism. As such, all patients with a confirmed LD or autism who die are referred to the 'service improvement programme for people with a learning disability and autistic people' (LeDeR). An external review is then undertaken to identify learning by reviewing key episodes of health and social care the person received that may have been relevant to their overall health outcomes.

16.2 To support the external LeDeR review, an internal SJR is mandated for all patients with an LD or autism who die whilst receiving care as an inpatient in the Trust or within the ED. On completion, this is then forwarded to Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) for inclusion in the external LeDeR review. Learning identified through LeDeR reviews is shared within the organisation to inform quality improvements initiatives.

16.3 In total during the year 2023-24, there have been a total of 10 patients with a confirmed LD or autism reported to LeDeR, who died in the Trust either as an inpatient or in the ED. Four of these patients died within Q4. At the time of writing this report, all SJRs have been completed for deaths prior to Q4, and 3 remain incomplete for deaths within Q4.

16.4 Positive learning identified during Q4 2023-24 includes prompt nursing assessment including recognition of community 'Deprivation of Liberty' Safeguards procedure (DoLs) and Lasting Power of attorney (LPA), early referral to the Acute Learning Disability Liaison Team, ReSPECT completion and communication with the next of kin. Learning for improvement identified relates to delayed antibiotic administration, documenting evidence of DoLs or MCA assessment, and the potential for earlier recognition of deterioration and dying which may facilitate fast track discharge to a preferred place of care.

16.5 The provision of specialist support for SJRs mandated for patients who die in the Trust with a confirmed LD or autism remains unresolved on a permanent basis. However, it is understood that appropriate resource for a new specialist LD and Autism Lead role within the Trust is currently under review. It is anticipated that recruitment to this post would potentially facilitate appropriate and sustainable support for the SJR process for both LD and Autism, moving forwards. Meanwhile, support from an LD Specialist Nurse on a temporary staffing basis has been agreed, with additional support from the Mental Health Specialist Leads in the Trust dependent on their capacity.

17.0 Deaths of patients with a Serious Mental Illness (SMI)

17.1 Adults who are diagnosed with a SMI are at increased risk of dying prematurely before the age of 75 in relation to other individuals. In accordance with the National Quality Board guidance (NQB 2017) SJRs are mandated for all patients who die within the Trust where a diagnosis of a SMI has been confirmed. A clinical review of care is undertaken, supported thereafter by a focused review by the Mental Health Clinical Nurse Specialist in the Trust.

17.2 During 2023-24, there were a total of 10 deaths identified where the mental health team confirmed that the patient had an SMI, 2 of which occurred within Q4. At the time of writing this report, 6 of the SJRs have been completed, a Divisional Investigation and Duty of Candour has been completed for 1 case and 1 SJR was superseded by a Coroner's Inquest. Both of the SJRs remain outstanding from deaths within Q4 2023-24, due to delays with availability of the notes following Clinical Coding and capacity of the Mental Health Specialist Lead.

17.3 Learning collated through the review of care provided to patients who die with an SMI informs the development of a quality improvement action plan managed by the Mental Health Clinical Nurse Specialist in the Trust. Learning is shared with relevant key stakeholders including clinical staff, the Trust's Safeguarding Operational Group, the Safeguarding Assurance Committee and the Trust Learning from Deaths Group, where a quarterly update is a standing agenda item.

18.0 Risk Register

18.1 There is one risk that remains on the Trust Risk Register relating to recruitment within the Corporate Learning from Deaths team. There has been turnover within the team and difficulties experienced recruiting to the specialist roles. Whilst the current recruitment freeze within the Trust initially impacted on vacancies, this has now been resolved and recruitment is in progress.

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June 2024