The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 September 2024

Agenda item	134/24			
Report Title	How We Learn from Deaths and Medical Examiner / Bereavement Service Quarter 1 2024-2025 Board Assurance Report			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Author	Dr John Jones, Executive Medical Director			
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	√	
Well Led	√	Our partners		
Consultation Communication	Trust Learning from Deaths Group, 1st August 2024 Quality Operational Committee, 20th August 2024 Quality & Safety Assurance Committee, 27th August 2024			
Executive summary:	• Plans for the statutory role of the Medical Examiner service starting in September 2024 and extension to community are progressing well. • The Trust's SHMI remains below expected and emergency department mortality remains separately monitored internally in the absence of a national benchmark. • The SJR tool remains well used with themes identified. A rating of 'good' or 'excellent' care was awarded in 63.5% of the completed SJRs in Q1 with 13.5% awarded a 'poor' care rating. These are managed through the relevant governance forums in the Trust. • Education and process review being used to increase the proportion of death certificates completed within target of 3 days. • The problem in care identified most frequently by SJR reviewers is problems with initial assessment, investigation or diagnosis. This remains consistent with the previous Q4 2023-24 • Septicaemia continues to be the condition with the highest number of excess deaths across the Trust. A collaborative review is in progress. • Two deaths have been deemed more likely than not due to problems in healthcare and therefore potentially preventable following presentation at RALIG during Q1			
Recommendations for the Board:	The Board is asked to **note** the report.			
Appendices:	None			

1.0 Introduction

1.1 This is a summary report specifically prepared for Board recognising that more detailed reports are scrutinised by the Quality Operational Committee (QOC) and the Quality and Safety Assurance Committee (QSAC).

2.0 Summary of Hospital Deaths reported to the Medical Examiner Service

2.1 There were 522 deaths across both hospital sites during Q1 recorded by the Medical Examiner (ME) & Bereavement service, which was a reduction of 45 deaths reported in Q4, and a decrease of 24 deaths from the same period in 2023. The ME service has reported this data to NHSE as part of the ME quarterly data return.

3.0 Medical Examiner Scrutiny

3.1 Two cases did not have ME review as they were referred directly to the coroner. Five cases did not have contact to next of kin, either due to no next of kin being identified or calls not returned.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 80 non-coronial cases did not have an MCCD completed within the target of 3 days and a review of processes between the ME and Bereavement Offices has contributed to improvement along with a commitment from the treating clinician attending the department in a timely manner to complete death certification. This approach has involved attendance at the junior doctor induction sessions during August 2024. Death certification reforms and legislative changes to support the wider education of this level of doctors were also outlined at this time.

4.2 A small number (12) of MCCD certificates were rejected by Registration Services. In the statutory system, the ME will be required to sign the new MCCD to demonstrate proportionate review has taken place, and that they approve the cause of death offered by the attending physician. The Registrar will be unable to “reject” an MCCD and refer a death to the coroner, and any queries that they may have with an MCCD, will be raised directly with the ME service and not with the coroner.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 There were 25 deaths in Q1 where the Medical Examiner recommended an SJR which is a reduction from the previous quarter and as a result of the overall reduction of deaths during this period.

5.2 The Medical Examiner service raised potential learning in 81 cases. These were referred to the relevant divisions and specialties for review through their governance processes.

5.3 During discussions between the next of kin and the Medical Examiner, 14 families were advised to contact PALS to raise concerns.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 105 referrals of which the coroner took no further action in 59 of the cases and took 46 cases to investigation by authorising either a post-mortem or inquest.

7.0 Service Highlights

7.1 The Department of Health and Social Care announced in April 2024 the Medical Examiner System will become statutory on the 9th September 2024 and full implementation of the death certification reforms will take place from this date.

7.2 A full update has been provided to the ICB with progress in engaging GP practices across the system, and information shared with what the death certification reforms means for them.

By the end of Q1, 22 community providers have on-boarded and are routinely referring deaths to the ME service including, the Severn Hospice, RJAH & Shropshire Community NHS Trust. A total of 199 community deaths were referred and reviewed by the ME service during this quarter, which is an increase of 59 cases from the previous quarter.

7.3 Medical Examiners have expressed their willingness to take part in an out of hours on call system.

7.4 Robust processes for escalating concerns and identifying learning in community cases has been established with the Integrated Care Service and has been disseminated across the service.

8.0 Summary of Hospital Deaths: Crude Mortality

8.1 Of the 522 deaths managed by the Medical Examiner Service, 455 occurred as an inpatient and 91 occurred within the emergency department (ED). This figure compares to 546 deaths in the comparative quarter during 2023-24, representing an overall decrease of 24 deaths.

As referenced in the Q4 2023-24 report, the spike in crude mortality across the Trust, in particular within the ED, was not repeated during 2023-24. Whilst there was a slight increase in the number of deaths for the comparable period in 2023-24, this was considered to be in line with seasonal variation. At the end of Q1, common cause variation for crude mortality continues to be demonstrated in the Statistical Process Charts (SPC) 1,2 and 3 below

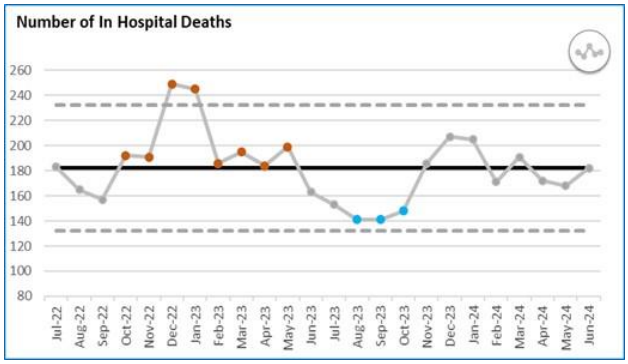

Chart 1 Trust Crude Mortality

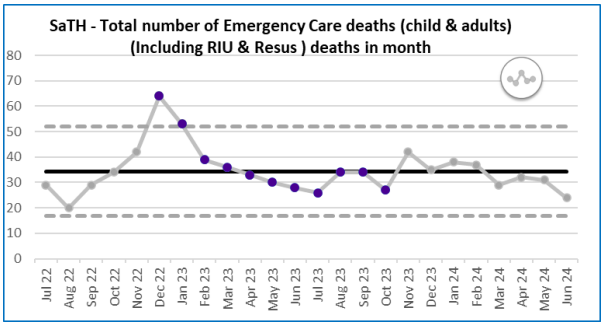

Chart 2 ED Crude Mortality

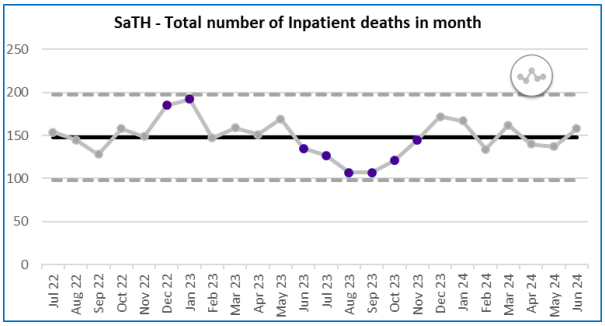

Chart 3 Inpatient Crude Mortality

A review of additional datasets that may be relevant to mortality within ED is currently in progress to help provide wider context to the learning from deaths agenda.

8.2 Of the 522 deaths in Q1 2024-25, 237 (45% of all deaths) were observed at the Princess Royal Hospital (PRH) and 285 (55% of all deaths) were observed at the Royal Shrewsbury Hospital (RSH). Inpatient deaths are included within the SHMI data provided to the Trust so we have a national standardised comparator but there is no similar analysis for emergency department deaths. Our emergency department deaths are presented below for both our hospitals.

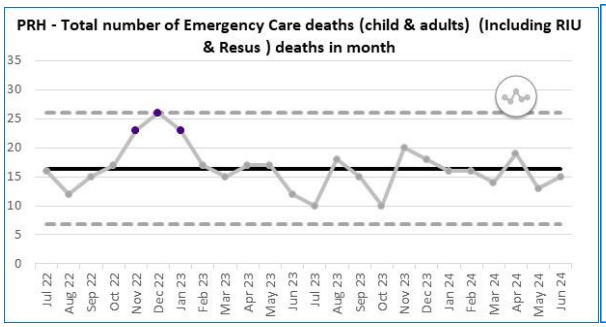

Chart 4 PRH Deaths in ED

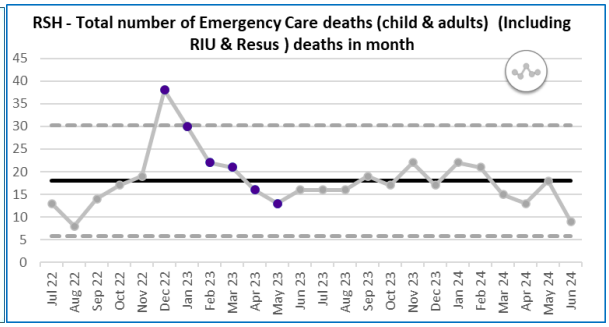

Chart 5 RSH Deaths in the ED

9.0 Summary Hospital-level Mortality Indicator (SHMI)

9.1 SHMI is a risk adjusted index that includes deaths in hospital as well as those which occur within 30 days of discharge and now includes patients with a primary diagnosis of COVID-19. The Trust's SHMI for January 2024, the latest available data, is 93.09 which is below the national average of 100. This is largely driven by a decreasing trend in observed deaths against a slight increase in expected deaths.

9.2 SHMI Excess Deaths: Septicaemia

Septicaemia continues to be the primary diagnosis condition with the highest number of “excess” deaths across the Trust (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. A collaborative review of patients within this cohort, led by the Deteriorating Patient team is underway. A review of the data for deaths where septicaemia was the primary diagnosis code has also been undertaken by CHKS and presented at the Trust Learning from Deaths Group in June 2024 to support this wider piece of work. A review of clinical coding is usually undertaken alongside a clinical review however this is likely to be delayed due to resource challenges within the Clinical Coding team in the Trust.

9.3 SHMI Excess Deaths: Covid-19

The primary diagnosis condition with the second highest number of “excess deaths” across the Trust is Covid-19. Until recently this condition was excluded from SHMI. A preliminary review has been undertaken by CHKS to provide greater detail around this, the cohort will be reviewed from a coding perspective and a deep dive clinical review will be undertaken should the condition continue to flag in this way.

9.4 Mortality Screening:

Clinical colleagues submitted 234 online mortality screenings tools of which 81 were completed for deaths within the quarter. Of these, 29 were classed as ‘positive’, which means that learning was identified which may trigger an SJR. These cases also include ones where good practice was identified. All positive screening cases are 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 complaint or Datix investigation. In these circumstances, a review of care is not usually duplicated.

9.5 Structured Judgement Reviews – Performance:

18% of deaths that occurred in Q1 have been reviewed using the SJR methodology with a reduction in timeliness from 80% to only 67% being completed within 8 weeks of the patient’s death. This was caused by a combination of staff absence, capacity in clinical coding, impact of some complex secondary reviews and a change in the platform used for SJRs. Care ratings of good or excellent were provided in 63.5% of the SJRs completed, with 13.5% rated as poor or very poor. This is broadly similar to the ratings reported for SJRs completed in Q4 2023-24. Of the 95 SJRs completed, 46 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. At the time of writing this report there are 15 SJR Datix awaiting submission for SJRs completed in Q1

9.6 Structured Judgement Reviews – Sources:

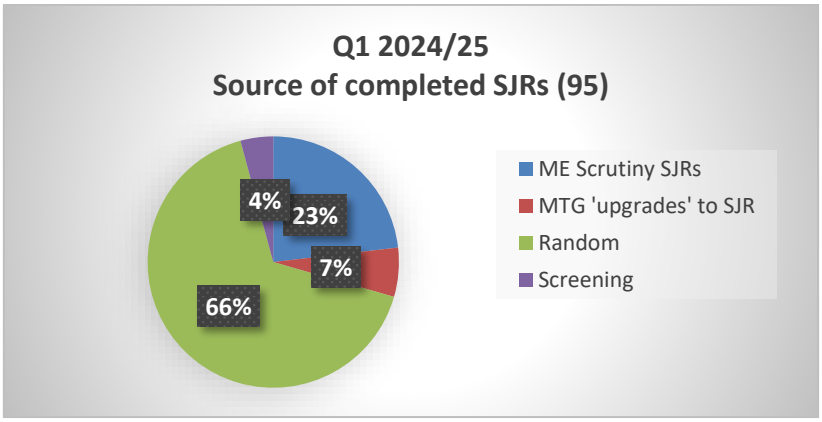

Chart 6 Sources of SJRs completed in Q1 2024-25

9.7 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) gradings for Structured Judgement Reviews completed during Q1 2024-25:

NCEPOD	Q4 2023-24	Q1 2024-25
Good practice	42.6%	45.8%
Room for improvement in clinical and organisational care	8.3%	21.9%
Room for improvement in clinical care	33%	19.8%
Room for improvement in organisational care	11.1%	9.4%
Less than satisfactory	7.4%	3.1%
Grand total	**100%**	**100.0%**

9.8 Bereaved families and carers have the opportunity to discuss the care provided to their loved ones during Medical Examiner Scrutiny of each case. Significant concerns were raised by the bereaved during Medical Examiner Scrutiny in 11 cases where the patient died during Q1.

At the time of writing this report, formal complaints have been raised in 3 of the cases. The concerns raised by the bereaved in the remaining cases are being managed through the most appropriate review including SJR, safeguarding and patient safety Datix. A Patient Safety Incident Investigation (PSII) has been commissioned in one case.

Significant concerns raised by bereaved families or carers for patients who died during Q1 include those relating to nursing care and clinical observations, dementia and risk of falls, appropriate use of anticoagulant therapy, end-of-life care, communication, discharge issues, and delays in investigation, diagnosis or management of conditions.

10.0 Learning to Improvement

10.1 Positive learning themes identified during Q1 through the completion of SJRs, as well as, the wider Learning from Deaths processes, including the weekly MTG relate to:

- Good evidence of appropriate investigations and escalation to different members of the multidisciplinary team, adhering to guidelines, internal policies, and seeking suitable external advice when required.
- Good documentation of care, multidisciplinary reviews, medical and nursing interventions, alongside other allied healthcare professionals, completed in a timely manner.
- Compassion and care demonstrated.
- Clear communication with relatives, allowing their involvement in the care and decision making.
- Appropriate ReSPECT discussions involving patient and relatives, and early recognition of dying. Implementation of Palliative and End-of-Life Care (PEoLC) and Swan pathway were comprehensively documented as per policy.
- Frequent medical reviews and patient observations as per policy facilitating appropriate treatment planning.
- Evidence of best practice across the multidisciplinary team.
- The timely recognition of clinical issues resulted in appropriate review of treatment plans, investigations, and improved clinical management.
- Holistic care with evidence of compassionate engagement and support provided to patients and relatives, provision of extended visiting hours during the patients' last days and hours of life.

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 to provide personal recognition of the quality of care provided as well as promote the replication of good practice to impact wider quality improvement within the Trust.

10.2 When completing SJRs, reviewers assign any problems to categories.

10.3 The top 3 categories identified by reviewers in SJRs completed during Q1 were:

1. Problem in initial assessment, investigation, or diagnosis. This category is consistent with the previous quarter.
2. Problem leading to readmission. This category differs from Q4 2023-24 where the category was "Problem of any other type".
3. Problem related to initial or ongoing treatment and management plan. This category again differs to the previous quarter where the category "Problems in team communication" was in the top 3.

10.4 Key themes of learning identified through SJRs completed during Q1 as well as the wider Learning from Deaths processes including the weekly MTG group, relate to:

- Issues concerning the provision of PEoLC include communication with the family and multidisciplinary team, lack of clear documentation of ceiling of care, and delayed recognition of active dying including failure to initiate Swan care pathway. This is a consistent theme from previous reports. 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). These include simulation training, bespoke training packages for ward-based staff and advanced communication skills course being developed by the PEoLC team.
- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form issues. A Trust clinical lead for ReSPECT was recruited in January 2024 and the Learning from Deaths team disseminate learning appropriate to support the programme of improvement work currently being developed. A quarterly update of this work to the Trust Learning from Deaths Group is in place.
- Patients deemed medically ready for discharge who then deteriorate prior to the discharge being completed.
- Ambulance offload delays and delays in initial assessment and medical review within the ED.
- Delay in completion, reporting and review of laboratory and imaging investigations resulting in delayed diagnosis and treatment plan, including delay in antibiotic administration.
- Issues around pain assessment and management including the use of the Abbey pain score.
- Discharge and readmission issues including discharge planning and failed discharge.
- Management of sepsis – delay in initiation of treatment and adherence to sepsis management protocols. The Learning from Deaths team and the Deteriorating Patient Specialist Nurses continue to work collaboratively to support wider improvement work relating to sepsis and the deteriorating patient. Sepsis 'validation' work, which was implemented in January 2022 to support the

identification of key learning themes, has now ceased and specific learning identified is being managed through PSIRF as a Trust priority.

- Delay in referrals and clinical reviews from specialities and specialist teams, such as the stroke team, Diabetes Specialist Nurse, Dietitian, Respiratory Specialist Nurse and Speech and Language Therapy (SALT).
- Treatment Escalation Plans for the management of patient deterioration.
- Medication issues – these are disseminated to relevant stakeholders including the Medicines Safety Officer for oversight and triangulation.
- The management of nutrition has been recognised as an emerging theme including late referrals to dietitian and missed recognition of poor nutritional state, incorrect completion of Malnutrition Universal Screening Tool (MUST), documentation of patient weight and incomplete food charts. Learning identified will be shared with relevant stakeholders in the Trust including the Quality Matrons, to support a wider improvement initiative currently being developed. It is envisaged that this learning will be shared with the Nutritional Steering Group and the Nutrition Supplements Steering Group. Learning should also feed into any relevant actions arising out of other related patient safety investigations.

10.5 The Learning from Deaths team work closely with healthcare professionals across the organisation as well as 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. This provides the opportunity to appropriately share and triangulate identified learning arising from the learning from deaths agenda and positively influence quality improvement initiatives for the communities we serve. A formal referral process has been in place since January 2024 to ensure that the ICB is provided with oversight of all identified learning that relates to system partners external to SaTH. Weekly formal handover meetings are held between divisional Quality Governance teams and the Learning from Deaths team to facilitate appropriate dissemination of learning to the wider clinical and non-clinical teams. Monthly divisional reports to the Trust Learning from Deaths Group provide a summary of triangulated learning across the specialities and an opportunity to share improvement work within the divisions arising from the learning from deaths agenda.

11.0 Maternal Mortality

11.1 During Q1, there has been one maternal death reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries). The death occurred outside of the Trust and was reported to MBRRACE-UK within the required timeframe.

12.0 Paediatric Mortality

12.1 There were 9 paediatric deaths across the Shropshire, Telford and Wrekin Integrated Care System (ICS) notified through the Child Death Overview Panel (CDOP) during Q1. Three of these were neonatal deaths which occurred within the Trust, although these did not fall within the remit of the Medical Examiner Service at SaTH. These deaths have been detailed at section 14 of this report. There were no paediatric deaths that occurred on the children's ward or in the ED within the Trust. All child deaths are reviewed within the CDOP statutory process.

13.0 Perinatal Mortality

13.1 During Q1, there were 2 early and 1 late neonatal deaths where the baby was born over 24 weeks gestation and met the criteria for MBRRACE reporting, 1 stillbirth over 24 weeks and 1 late fetal loss between 22+0 and 23+6 weeks of pregnancy. These deaths currently fall outside of the remit of the Medical Examiner Service within the Trust and therefore are not included with the overall Trust mortality data given within this report. Trust neonatal deaths are based on date of death and financial year whereas MBRRACE use calendar years and date of birth.

13.2 The MBRRACE-UK Perinatal Mortality Report: 2022 Births within the Shrewsbury and Telford Hospital NHS Trust, has been received by the Trust. The full MBRRACE-UK report for perinatal deaths will be published in September 2024.

A divisional review of Trust specific data with a focus on stillbirths was presented to the Quality Operational Committee in June 2024. The adjusted and extended stillbirth rate is around average for similar Trusts and Health Boards. There were no trends identified in the report that were thought to contribute to the stillbirth outcomes. Trust specific data continues to show higher than average neonatal mortality compared to similar Trusts and Health Boards. A divisional review of the report is due to be presented to the Quality Operational Committee and the Quality and Safety Assurance Committee in August 2024. A data reporting error has been noted within the category of 'stabilised and adjusted neonatal mortality rate excluding deaths due to congenital abnormalities' which was escalated to MBRRACE in May 2024. The report cannot be retrospectively amended. There are two specific areas of good practice that are highlighted in the report:

- The families of all babies who were born and subsequently died at SaTH (100%) as well as those experiencing a stillbirth, were offered a post-mortem. This is higher than the national average of 91%.
- A review of care using the PMRT was completed for all babies who died that met the criteria. All remaining deaths that did not meet the criteria, were reviewed within child death review meetings locally.

Areas for improvement were noted to be:

- Documentation especially regarding neonatal resuscitation and transfer to the neonatal unit.
- Use of a neonatal electronic patient record (EPR) to compliment the use of the maternity EPR would increase accuracy of documentation and data collection.
- Need to review the pathway for babies born outside maternity to be transferred to the delivery suite where specialist team and equipment is available for stabilisation. A Standard Operating Procedure has been completed to support this.

13.3 The 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 following the submission of factual accuracy comments by the Trust on 28th August 2024. The action plan arising from the initial findings was presented to the Quality Operational Committee in April 2024 and progress will be monitored through the Maternity and Neonatal Transformation Programme. Once received by the Trust, the report will be presented to QSAC and then

to Board taking into account any redactions required to maintain individual's confidentiality.

14.0 Deaths of patients with a confirmed Learning Disability, Autism or Serious Mental Illness (SMI)

14.1 Support for specialist input for the review of patients who have died with a learning disability or serious mental illness is provided by the relevant specialist nurses, although this has been challenging during the quarter due to limited availability of specialist support from the current part-time Learning Disability Lead. As such SJRs completed for patients with a learning disability or autism is limited to a clinical review of care only. Recruitment is underway for a substantive Learning Disability Lead which, once in post, should help resolve the situation. 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.

14.2 In the Q4 2023-24 iteration of this report, 3 SJRs were outstanding for patients with a confirmed learning disability or autism who had died. These reviews are now complete. One case was reviewed as a serious incident investigation. All reviews are provided for inclusion within the external LeDeR review that takes place.

14.3 During Q1, there have been 5 deaths of patients who died within the Trust with a confirmed learning disability or autism. All of these cases have been referred to LeDeR. One case is currently under investigation within PSIRF using the 'After Action Review' learning response. An SJR has been completed in 2 of the other cases. The completed SJRs have been shared with the STW ICS for the external LeDeR review. An SJR remains outstanding for two remaining cases.

14.4 Positive learning identified through the Learning from Deaths processes for patients who have died with a confirmed learning disability or autism during Q1 includes:

- The provision of compassionate care by all members of the multidisciplinary team.
- Excellent planning and involvement of the multidisciplinary team including the Learning Disability team.
- Use of ReSPECT.
- Clear documentation around diagnosis and treatment plans.
- Prompt escalation and review in ED
- Excellent out of hours medical reviews.
- Good communication with next of kin and appropriate use of the Mental Capacity Assessment (MCA), Best Interests (BI) and Deprivation of Liberty Safeguards (DoLS) forms.

14.5 Learning for improvement identified includes issues relating to:

- Nutrition and inconsistent documentation of patient intake.
- Delays in assessment by specialist teams.
- Delays in investigations leading to delayed diagnosis and procedures.

14.6 The Learning Disabilities Mortality Review (LeDeR) Annual Report April 2022 to March 2023 has now been published. This will be reviewed and presented within relevant

forums within the Trust and key learning and actions will be reported in future iterations of this report.

14.7 During Q1, there were 4 patients who died where the mental health specialist nurse confirmed that the patient had an SMI. A PSII has been commissioned for one of these cases and is in progress. A Datix investigation is underway for another case. Two SJRs remain outstanding but are within the 8-week timeframe for completion. Quality improvement plans will be managed by the Mental Health CNS.

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

15.1 With the introduction of PSIRF, deaths identified at the outset to be more likely than not due to problems in healthcare are investigated as a Patient Safety Incident (PSII). Deaths reviewed using the SJR methodology where the preventability scale is rated as 'greater than 50:50' will be subject to further review facilitated by the Divisional Quality Governance teams and clinical colleagues and referred for a PSII as appropriate, with oversight from the Trust Review Actions and Learning from Incidents Group (RALIG).

15.2 During Q1, there have been two deaths presented to RALIG where the death was deemed more likely than not due to problems in healthcare and therefore considered potentially avoidable. A detailed summary of learning identified within these investigations is provided in the monthly Incident Overview Report presented to the Quality and Safety Assurance Committee and the Quarterly Learning from Incidents Report presented to the Quality and Operational Committee and as such, are not further detailed within this report.

16.0 Regulation 28 – Reports to Prevent Future Deaths

16.1 No Regulation 28 Reports have been received in the Trust since May 2021.

17.0 Risk Register

17.1 At the time of writing this report, there are no open risks on the Trust Risk Register. The one risk relating to recruitment within the Corporate Learning from Deaths team has now been closed.