The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 16th January 2025

Agenda item	020/25			
Report Title	How We Learn from Deaths Quarter 2 2024-2025 Report			
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			
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, 5th December 2024 Quality Operational Committee, 13th December 2024 Quality & Safety Assurance Committee, 31st December 2024			
Executive summary:	• Risk adjusted mortality (SHMI) to March 2024 as well as crude mortality performance within SaTH during Q2 2024-25 is 'as expected'. Sepsis remains the condition with the highest number of excess deaths across the Trust. • Mortality performance monitoring including SHMI is impacted by the challenges being experienced within the internal Data Warehouse. • The number of excess deaths relating to inpatient admissions where there were delays of 12 hours or more in the ED, as predicted through the Royal College of Emergency Medicine (RCEM) modelling has not materialised locally within the STW System. • ED performance data published by NHS Digital reports a higher rate of crude mortality in ED against ED attendances in SaTH for 2023-24 compared to the CHKS Peer Group and the national figure. • The final report following the invited external expert neonatal review completed in Q3 2023-24 has been received by the Trust. Action plans will be monitored through the Maternity and Neonatal Transformation Assurance Committee. • A rating of 'good' or 'excellent' care was awarded in 71% of the completed SJRs in Q2 with just under 11% awarded a 'poor' care rating. • Two deaths have been deemed more likely than not due to problems in healthcare and therefore potentially preventable.			
Recommendations for the Board:	The Board is asked to **note** the report.			

1.0 Introduction

1.1 The Shrewsbury and Telford Hospital NHS Trust (SaTH) considers mortality to be an important metric relating to the quality of services provided within the organisation. The Learning from Deaths agenda utilises both quantitative and qualitative data including feedback from the bereaved, to identify learning and inform wider improvement activity across the Trust.

1.2 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: Crude Mortality - Internal Performance Monitoring

2.1 Of the 446 deaths recorded by the Medical Examiner Service within the Trust during Q2, 369 occurred as an inpatient and 77 occurred within the Emergency Department (ED). This figure represents a decrease of 78 deaths reported in Q1 and an increase of 11 deaths from the comparative quarter during 2023-24.

2.2 Statistical Process Charts (SPC) 1-5 (source SaTH Performance Team) show the overall number of observed deaths across the Trust, inpatient deaths and deaths that occurred within the ED across both sites both by month and as a percentage of all deaths within the Trust.

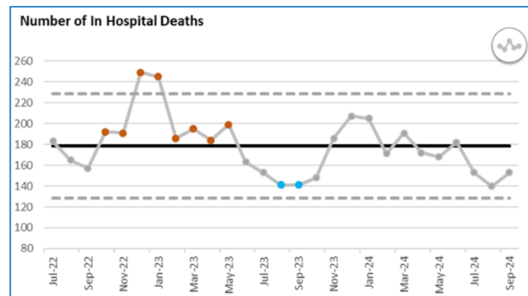

Chart 1 Trust Crude Mortality

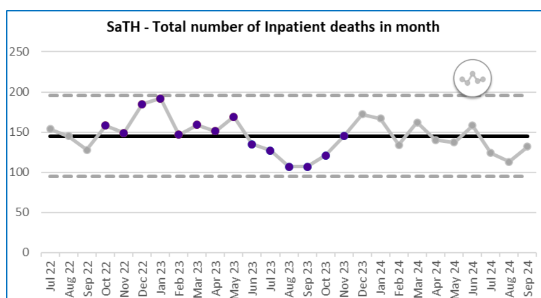

Chart 2 Inpatient Crude Mortality

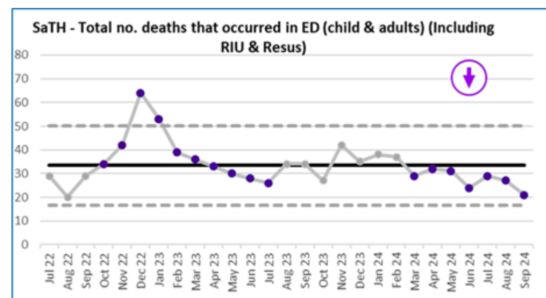

Chart 3 ED Crude Mortality

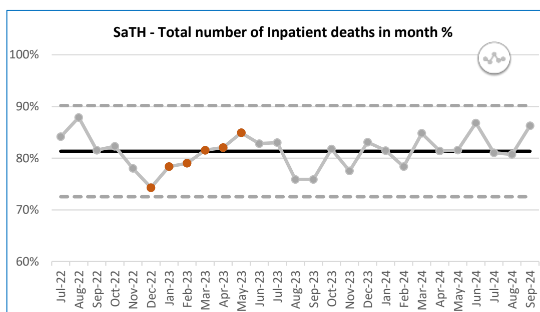

Chart 4 Inpatient Mortality % All Deaths

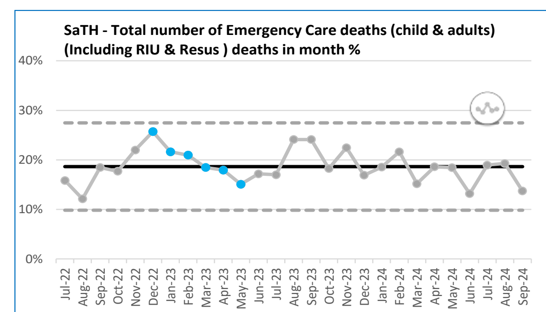

Chart 5 ED Mortality % All Deaths

2.3 Of the 446 deaths in Q2 2024-25, 43% were observed at the Princess Royal Hospital (PRH) and 57% were observed at the Royal Shrewsbury Hospital (RSH). This distribution is broadly in line with Q1 2024-25.

2.4 In line with previous quarters, approximately 80% of observed deaths within the Trust during Q2 2024-25 occurred within the Medicine and Emergency Care (MEC) division and approximately 20% occurred within the Surgical and Cancer Care (SACC) division, with less than 0.5% occurring within the Women and Children's division.

3.0 National Risk Adjusted Mortality Indicators - Summary Hospital-level Mortality Indicator (SHMI):

3.1 SHMI is a risk adjusted index that includes inpatient deaths as well as those which occur within 30 days of discharge. SHMI now includes patients with a primary diagnosis of COVID-19. It does not include patients who die within the ED and who are not categorised as inpatients. The Trust SHMI for March 2024, the latest available data, is 97.59 which is below the national average of 100.

3.2 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 risk adjusted model). It has increased from the previous period and was higher than the peer average. A review of the data for deaths where septicaemia was the primary diagnosis code has been undertaken by CHKS and was presented at the Trust Learning from Deaths Group in June 2024 to support a wider collaborative piece of work that has been agreed with Leads from the Deteriorating Patient Group. A preliminary review of clinical coding relating to septicaemia has been undertaken and no initial concerns identified although a more detailed review of this has been recommended as part of the wider Trust improvement work relating to Deteriorating Patients to identify if there is any learning for clinical staff which may have a positive impact on the SHMI metric.

3.3 SHMI Excess Deaths: Pneumonia:
Whilst pneumonia is the primary diagnosis condition with the second highest number of deaths across the Trust, it remains in line with the peer average.

3.4 SHMI Excess Deaths: Covid-19:
The primary diagnosis condition with the third highest number of excess deaths across the Trust is Covid-19. Until May 2024 this condition was excluded from SHMI. Preliminary reviews have been completed by both the Trust Clinical Coding team as well as CHKS and presented for discussion at the Trust Learning from Deaths Group this quarter. No specific actions have been identified at this time. Further monitoring of this will only be possible once the Data Warehouse issues detailed at section 4 are resolved.

3.5 SHMI Excess Deaths: Primary diagnosis conditions awaiting further review:
The indices for the following primary diagnosis conditions also with the highest number of excess deaths within the Trust in the latest quarter to the end of March 2024, have increased and are higher than the CHKS Peer Group:

- Cancer of the pancreas.
- Fracture of the upper limb.
- Coma, stupor and brain damage.

A preliminary review of these conditions is underway with next steps to be determined. Any learning identified will be fed back through the Trust Learning from Deaths Group.

3.6 No further monitoring of the Trust SHMI or of primary diagnosis conditions through the SHMI indicator including benchmarking against the CHKS Peer Group, is possible until the current problems with national data submissions through the Data Warehouse as detailed in section 4 below, are resolved.

4.0 Impact of Trust Data Warehouse Challenges within the Learning from Deaths Agenda

4.1 Since April the Trust has experienced considerable challenges with the technical structure of the internal Data Warehouse and the ability to generate an accurate activity and income position. Despite various attempts to rectify the issues, the Trust took the decision to cease national submissions that relate to Secondary Uses Service (SUS) and Service Level Agreement Monitoring (SLAM) until assurances could be made that the data provides a true reflection of the Trust position.

4.2 The impact of pausing these submissions is considerable, both internally and wider across the region, so alternative solutions were considered to bridge any gap in reporting. Unfortunately, no solution was identified that would generate data of sufficient accuracy to provide the level of assurances required and so until the Data Warehouse issues are resolved, the Trust remains unable to report on this information. Within the Learning from Deaths agenda this specifically impacts the Summary Hospital-level Mortality Indicator (SHMI), ability to calculate the Crude Mortality Rate (CMR) and various other performance metrics within the Learning from Deaths Dashboard including depth of coding and palliative care coding. Local improvement work to monitor 30-day mortality relating to attendances in the ED including those where a delay has been experienced will also be impacted until the issue is resolved.

5.0 Excess Deaths Relating to Admitted Patients Who Experienced Long Delays In The Emergency Department

5.1 An extraordinary report was presented to the Trust Board of Directors in December 2023 detailing the findings of a collaborative assurance review completed within SaTH into the increase of deaths within the ED during Q3 2022-23. Within this report, the correlation between length of stay in ED and increased mortality was explored in line with the national picture.

5.2 On the 1st April 2024 the RCEM published an article[1] stating that there were almost 300 deaths a week in England in 2023 associated with long waits in the ED and that there were almost 14,000 excess deaths related to delays of 12 hours or more, equating to more than 268 deaths per week.

5.3 Analysis has been undertaken within the Shropshire, Telford and Wrekin Integrated Care Board (STW ICB) to identify if the number of excess deaths detailed within the RCEM modelling has been realised locally. A paper presented these findings to the Joint Health Overview and Scrutiny Committee (JHOSC) on the 10th September 2024, titled “Oversight and Assurance of Mortality Rates in the Emergency Department”. This paper identified that the level of excess mortality within the STW ICS based on the RCEM model has not materialised and that admitted patients being treated in SaTH who have experienced long delays in the ED, have not experienced the mortality levels anticipated by the RCEM model.

5.4 NHS Digital has published a dataset that reports on various aspects of ED performance for 2023-24 including deaths that occur in the ED as a percentage of the overall number of ED attendances. Based on crude mortality data which does not consider other relevant variables such as acuity, the rate for SaTH is higher when compared to the CHKS Peer Group and the national figure. This is currently under review with relevant stakeholder involvement.

5.5 Work continues within the Trust to review harm related to long delays within the ED and improvement work continues through the wider Urgent and Emergency Care (UEC) Transformation Programme.

5.6 A review of the potential impact of upgrades to the current Emergency Care Data Set (ECDS) for patients in the ED who have been referred to a specialty and are awaiting admission to a ward, is underway. Implications for both the Trust SHMI and ED mortality data is as yet to be determined.

6.0 Structured Judgement Reviews (SJRs)

6.1 At the time of writing this report, 17% of deaths that occurred in Q2 have been reviewed using the SJR methodology against the NHSE recommended target of 15%. This is in addition to deaths which have been reviewed through other methods including datix investigations, coronial processes and the Formal Complaints process. 85% of the SJRs completed to date for deaths within Q2 were reviewed within 8 weeks of the date of death, an improvement from Q1 when performance had dropped to 67%. An overall care rating of good or excellent was provided in 71% of the SJRs completed during Q2, compared to 63.5% in Q1. An overall assessment rating of poor or very poor was identified in just under 11% of SJRs versus 13.5% during Q1, with the remainder being rated as adequate. A comparison of National Confidential Enquiry into Patient Outcome and Death (NCEPOD) gradings for the last 3 quarters are shown below:

NCEPOD	Q4 2023-24	Q1 2024-25	Q2 2024-25
Good practice	42.6%	45.8%	61.5%
Room for improvement in clinical and organisational care	8.3%	21.9%	8.7%
Room for improvement in clinical care	33%	19.8%	14.4%
Room for improvement in organisational care	11.1%	9.4%	7.7%
Less than satisfactory	7.4%	3.1%	7.7%
Grand total	**100%**	**100.0%**	**100%**

6.2 Of the 105 SJRs completed during Q2, 40 met the criteria for further submission of an SJR Datix based on identification of unexpected death, poor or very poor care, preventability scoring greater than 50:50, NCEPOD grading ‘less than satisfactory’, any problem in care where potential harm was identified or any case where the reviewer was not able to grade the care. These cases are discussed within relevant Trust Governance Forums for consideration as Patient Safety Incidents. All except two of these have been submitted. All SJR datix which were outstanding as reported in Q1 have now been submitted.

6.3 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. Significant concerns were raised by the bereaved during Medical Examiner Scrutiny in 9 cases where the patient died during Q2. At the time of writing this report, formal complaints

have been raised in 1 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.

Significant concerns raised by bereaved families or carers for patients who died during Q2 include those relating to communication, general ward care, lack of consultant cover at PRH over weekends, lack of rehabilitation service potentially contributing to falls and delay in initiation of planned procedures.

6.4 Sources of SJRs are shown at chart 6:

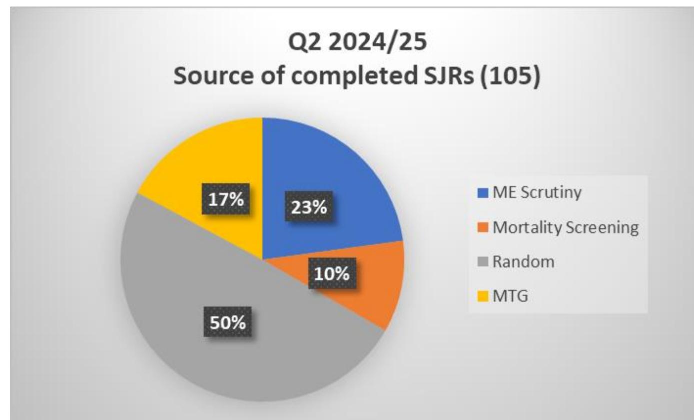

Chart 6 Sources of SJRs completed in Q2 2024-25

7.0 Learning to Improvement

7.1 A comprehensive summary of positive and negative learning themes identified through the wider Learning from Deaths processes including SJR completion and the weekly Mortality Triangulation Group (MTG) has been detailed in the full report scrutinised through QOC and QSAC.

7.2 Learning is disseminated to relevant internal and external stakeholders and may be incorporated into existing improvement programmes of work within the organisation including those relevant to the PSIRF Trust Priorities.

7.3 The top 4 categories identified by reviewers in SJRs completed during Q2 are consistent with previous quarters:

1. Problems in communication among teams, including verbal and written handover.
   Communication / escalation between specialty teams within the hospital including discharge liaison, complex discharge team, renal, urology and trauma and orthopaedic teams as well as communication within teams about end-of-life care leading to unnecessary delays, ownership of patients by medical teams, and referrals to specialist teams such as the dementia team.

2. Problems leading to admission or readmission, including transfer decision, admission avoidance, escalation planning and/or planning for admission avoidance.
   Includes issues around recent discharge followed by readmission with a similar issue, discharge to community ward followed by readmission to SaTH, ambulance offload delays and prolonged stay in ED.

3. Problem related to initial or ongoing treatment and management plan including preventative strategies.
   Repeated themes from previous reports around end-of-life care including delayed recognition of dying and delays to ReSPECT conversations, end-of-life care planning and pain management including appropriate Mental Capacity Act (MCA)/ Best Interests (BI) completion, delayed escalation of unwell or deteriorating patients, incomplete documentation relating to fluid balance charts, fluid restriction plans, intravenous fluid and insulin charts, bowel monitoring, nutritional assessments and nasogastric tube insertion proformas, assessment of patient suitability for care on the intensive care unit, failure to follow Trust guidelines relating to fluid prescription and lack of senior patient reviews.

4. Problem in initial assessment, investigation, or diagnosis. This category is consistent with the previous quarter.
   Delays in assessment and treatment as a result of ambulance offload delays or prolonged stays in the ED, problems with clinical assessment due to the requirement for multi-disciplinary team involvement including delays in specialty review, missed requirement for a safeguarding review, documentation of clinical assessments, availability of covid antiviral (one case) and appropriate adherence to sepsis pathway.

7.4 The Learning from Deaths team work closely with healthcare professionals across the organisation as well as the wider Integrated Care System for example, the 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. 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.

7.5 Following the introduction of the statutory Medical Examiner Service in September 2024, the Learning from Deaths team are currently working collaboratively with the Medical Examiner team to ensure that learning relevant to SaTH that has been identified through the scrutiny of community deaths is managed through the most appropriate process and ensure that family needs are met. Learning identified will then be disseminated appropriately or a further review commissioned to maximise learning opportunities or facilitate duty of candour as required.

8.0 Maternal Mortality

8.1 During Q2, there have been no maternal deaths to report to MBRRACE-UK.

9.0 Paediatric Mortality

9.1 There were 7 paediatric deaths across the STW ICS notified through the Child Death Overview Panel (CDOP) during Q2. None of these were neonatal deaths occurring within the Trust. There was one paediatric death that occurred on the children's ward and none

that occurred in ED within the Trust. All child deaths are reviewed within the CDOP statutory process.

10.0 Perinatal Mortality

10.1 During Q2, there were no early or late neonatal deaths which met the criteria for MBRRACE reporting. There were 3 stillbirths over 24 weeks and 1 late fetal loss between 22+0 and 23+6 weeks of pregnancy. These fall outside of the remit of the Medical Examiner Service and therefore are not included with the overall Trust mortality data given within this report.

10.2 The main learning points from completed PMRT reviews during Q2 relate to:

- The completion of partograms to monitor women during labour where a poor outcome is expected.
- The assessment of 'routine enquiry' questions.
- The offer of screening tests and urgent booking appointments for 'unbooked' women attending maternity triage to prevent delays in care.
- Timeframes around the 'Golden Hour' for the neonate.
- Training developed to improve documentation of neonatal respiratory management.
- Training requirements around the recognition and treatment of massive blood loss and disseminated intravascular coagulation in the neonate.
- Sharing of information between the midwifery / obstetric team and the neonatal team regarding maternal medications, neonatal alerts, safeguarding, and clinical risks identified in pregnancy or labour. A new checklist for babies admitted to the neonatal unit has been developed.

10.3 The MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2022 has been published. The report is currently being discussed at relevant governance forums in the Trust. A detailed summary will be provided in the Q3 iteration of this report.

10.4 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 MBBRACE-UK reports for 2021 and 2022, has now been received by the Trust. Family meetings have taken place with the Executive Medical Director and an action plan has been developed in collaboration with system partners. This will be monitored through the Maternity and Neonatal Transformation Assurance Committee. Summary findings within the review include:

- Recognition that since the publication of the first Ockenden Report in December 2020, maternity services within SaTH have taken huge strides to rebuild the service, staff teams, processes and culture.
- No evidence to indicate that the quality of care provided to babies by the neonatal service was substandard or directly contributing to the unit's outlier status with regards to perinatal mortality.
- Examples of good and excellent care, both in maternity and neonatal services.
- Aspects of care that were either poor, or in one case, very poor care, with significant room for improvement. This case involved paediatric services rather than neonatal services and has undergone internal review with learning identified. The case will also be reviewed through the CDOP process.
- The recommendation that neonatal mortality at SaTH is considered alongside neonatal mortality across the region as the West Midlands has the highest infant

mortality in England. Factors such as social determinants, poverty and ethnicity, should be investigated.

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

11.1 Specialist support for the mandated review (SJR) of patients who have died in the Trust with a learning disability, autism or an SMI is provided by the relevant specialist nurses. Whilst recruitment is in progress for a full-time Learning Disability Lead and temporary cover for the Mental Health Lead, dedicated support for SJRs remains challenging. Consequently these cases are currently limited to a review of clinical care only.

11.2 During Q2, there have been 3 deaths of patients who died within the Trust with a confirmed learning disability or autism referred to LeDeR. An SJR has been completed and shared with the STW ICS for the external LeDeR review in two cases. The other case is subject to a coronial investigation. All outstanding SJRs for patients who died in Q1 with a confirmed learning disability or autism, have been completed.

11.3 During Q2, there were 3 patients who died within the Trust where the Mental Health Clinical Nurse Specialist confirmed that the patient had a diagnosis of an SMI. A Datix investigation has been completed for one of these cases and an SJR completed for the remaining 2 cases to identify relevant learning.

11.4 In the Q1 iteration of this report, it was reported that there were 4 deaths in Q1 where it was confirmed that the patient had an SMI. Since this report, an SMI diagnosis has been confirmed for an additional death in Q1, making a total of 5. Four SJRs have been completed for these cases and a PSII has been concluded for the remaining case.

11.5 The latest LeDeR annual report for Shropshire, Telford and Wrekin 'LeDeR: Learning from Lives and Deaths of People with a Learning Disability and Autistic People, Shropshire, Telford and Wrekin, 1st April 2023 – 31st March 2024' has now been published. Key learning was shared at the Trust Learning from Deaths Group in September. During 2023-24, the STW ICB received 21 notifications of adult deaths of people who had died with an LD or autism and who lived within Shropshire, Telford and Wrekin.

11.6 The annual report highlights that there has been an increase in the number of individuals dying younger in STW, with the median age being 50 compared to 62 in 2022-23. There were more males than females dying, which is in line with the national picture and ethnicity in 90% of the reviews was recorded as White British. The leading causes of death during 2023-24 were aspiration pneumonia, which accounted for 19% of all the deaths reviewed, and bronchopneumonia which accounted for 14% of deaths reviewed. 9% of the deaths were linked to epilepsy and a further 9% linked to cancer. 53% of people died in their usual place of residence, an increase from 42% in 2022-23.

11.7 Key themes for learning from local LeDeR reviews undertaken during 2023-24 relate to:

- Completion of ReSPECT documentation.
- Learning Disability and cause of death.
- Identification and implementation of reasonable adjustments
- Use of Mental Capacity Act (MCA), Best Interests (BI) and Deprivation of Liberty (DoLs).
- Supporting documentation including hospital passports and pain profiles.
- Annual Health Checks.

- Training and education for those supporting individuals with an LD or autism.
- Oversight and accountability for the quality of care provided to supported individuals.

11.8 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.

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

12.1 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).

12.2 During Q2 there have been two deaths 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. As such, they are not further detailed within this report.

13.0 Regulation 28 – Reports to Prevent Future Deaths

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

14.0 Risk Register

14.1 There are no open risks relating to the Learning from Deaths agenda on the Trust Risk Register. The impact of the Data Warehouse challenges on the Learning from Deaths agenda has been incorporated into the wider Trust risk associated with this issue – risk 1078.

Dr Roger Slater, Trust Senior Clinical Learning from Deaths Lead
Fiona Richards, Head of Learning from Deaths & Clinical Standards
December 2024

References

1 Royal College of Emergency Medicine, 2024 "Almost 300 deaths a week in 2023 associated with long A&E waits despite UEC Recovery Plan"