The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 March 2025

Agenda item	048/25			
Report Title	How We Learn from Deaths Report Quarter 3 2024-2025			
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	√	1078
Well Led	√	Our partners		
Consultation Communication	Trust Learning from Deaths Group, 6 February 2025 Quality Operational Committee, 18 February 2025 Quality & Safety Assurance Committee, 25 February 2025			
Executive summary:	• The current challenges with the internal Data Warehouse prevent further analysis of risk adjusted mortality (SHMI) and other key performance metrics relevant to the Learning from Deaths agenda until a resolution has been identified. • As reported in quarter 2, NHS Digital has published a dataset that reports on various aspects of ED performance for 2023-24 including mortality in the ED. Based on crude mortality data, and not including variables such as acuity, the rate for SaTH is higher when compared to the CHKS Peer Group and the national figure. This dataset remains under review with relevant stakeholder involvement. A detailed review of mortality in the ED during 2023-24 has commenced. • The Learning from Deaths 'Getting to Good' improvement project coordinated by the Trust Project Management Office with Executive oversight, has been formally closed with the programme of work now maintained as 'business as usual'. • Three deaths are reported to Board this quarter which 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.			
Appendices	N/A			

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 522 deaths recorded by the Medical Examiner Service within the Trust during Q3 2024-25, 408 occurred as an inpatient and 114 occurred within the Emergency Department (ED). This figure represents an overall increase (inpatient and ED) of 76 deaths from Q2, but a decrease of 20 deaths from the comparative quarter in 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, by month and as a percentage of all deaths within the Trust. Inpatient deaths have decreased by 30 from the comparative quarter in 2023-24, accounting for 78.2% of all deaths in 2024-25, compared to 80.8% in 2023-24. Deaths in the ED have increased by 10 from the comparative quarter in 2023-24, accounting for 21.8% of all deaths compared to 19.2% in 2023-24.

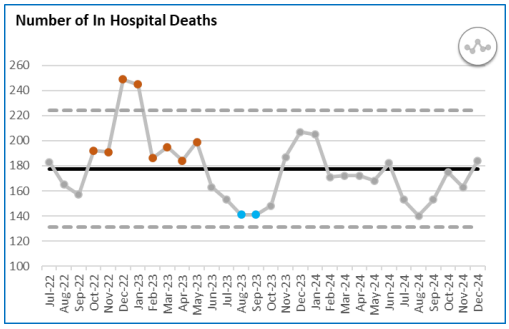

Chart 1 Trust Crude Mortality

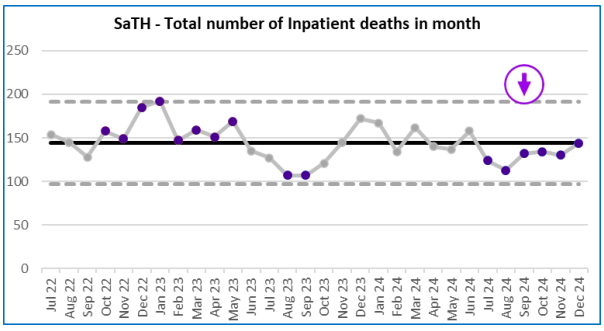

Chart 2 Inpatient Crude Mortality

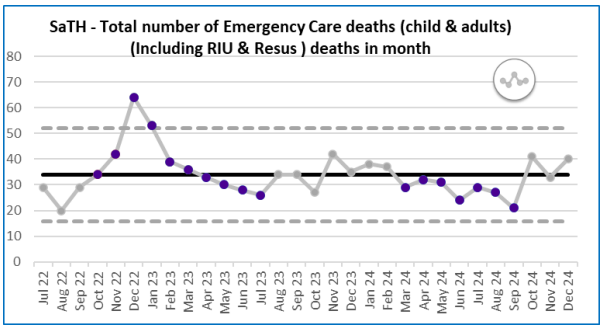

Chart 3 ED Crude Mortality

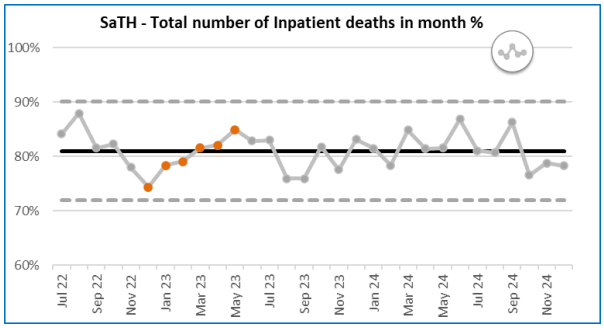

Chart 4 Inpatient Mortality % All Deaths

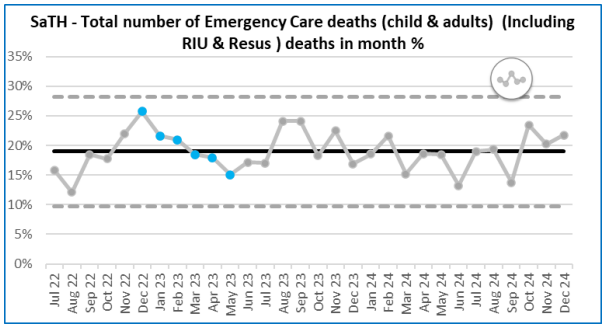

Chart 5 ED Mortality % All Deaths

2.3 Of the 522 deaths in Q3 2024-25, 42% were observed at the Princess Royal Hospital (PRH) and 58% were observed at the Royal Shrewsbury Hospital (RSH). This distribution is in line with Q2 2024-25.

2.4 In line with previous quarters, approximately 80% of observed deaths within the Trust during Q3 2024-25 occurred within the Medicine and Emergency Care (MEC) division and approximately 19% 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 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 which is reviewed as a monthly standing agenda item within the trust Learning from Deaths Group meeting.

3.2 Due to the current challenges within the Data Warehouse as detailed in the Q2 report, no further Trust SHMI updates or benchmarking against the CHKS Peer Group after March 2024 are available. Work continues to review the primary diagnosis conditions with the highest number of 'excess' deaths (more deaths than expected by the SHMI risk-adjusted model) across the Trust which were detailed within the Q2 report.

4.0 Mortality within the Emergency Department (ED)

4.1 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. As referenced in the Q2 report, this dataset remains under review with relevant stakeholder involvement.

4.2 A detailed review of mortality within the ED during 2023-24 has commenced. The terms of reference, scope and anticipated timeframe for the review are currently being finalised.

4.3 Delays in the ED are a common theme noted within SJRs and the wider Learning from Deaths agenda in Q3. This includes patients who have died whilst waiting for a bed, delays waiting for review by ED doctors, delays arising from issues with specialty referral, and delays experienced in ED following a failed discharge. Other learning for improvement relates to the identification of new confusion when completing the National Early Warning Score (NEWS) 2 in ED, fluid balance monitoring, intravenous fluid

management, and the completion of Mental Capacity Act (MCA), Best Interest (BI), and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms. Positive learning identified relating to care provided in the ED relates to prompt triage, good sepsis management, thorough nursing assessments, timely investigations, early triage, good nursing and medical documentation, escalation in accordance with policy, safeguarding management and early specialty review.

4.4 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.

4.5 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 yet to be determined.

5.0 Structured Judgement Reviews

5.1 At the time of writing this report, 9% of the deaths in Q3 have been reviewed using the SJR methodology against the NHSE 'Better Tomorrow' Programme Leads recommended target of 15% which was adopted locally. This is in addition to those that have been reviewed through other methods including Datix investigations, Coronial processes and the Formal Complaints process. The deterioration in performance has been driven by a higher level of planned leave and sickness within the small Corporate SJR reviewing team resulting in 43% of the Consultant Programmed Activity (PA) sessions for SJR completion being unavailable. Delayed notes availability arising from current capacity issues within the Clinical Coding team is negatively impacting the timely completion of SJRs and the percentage completed within 8-weeks from death has decreased from 85% in Q2 to 72% in Q3. Ad hoc support for SJR completion is provided by a bank senior nurse to facilitate a multi-disciplinary approach to case review whilst the potential for ad-hoc support from other substantive clinical colleagues to improve performance continues to be explored.

5.2 An overall care rating of 'good' or 'excellent' was provided in just over 61% of the SJRs completed during Q3, compared to 71% in Q2. An overall assessment rating of 'poor' or 'very poor' was identified in just over 9% of SJRs versus 11% during Q2, with the remainder being rated as 'adequate'. Cases where ratings of 'poor' or 'very poor' have been given are further reviewed at Divisional level and discussed within relevant Trust Governance forums for consideration as Patient Safety Incidents with appropriate management through the Patient Safety Incident Response Framework (PSIRF).

5.3 Sources of SJRs completed during Q3 are shown at chart 6

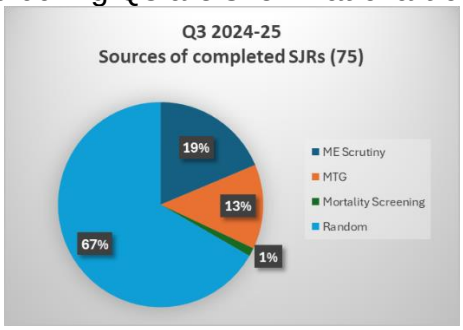

Chart 6 Sources of SJRs completed in Q3 2024-25

5.4 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 12 cases where the patient died during Q3.

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. Family meetings with a clinician may also be offered where appropriate.

Significant concerns raised by bereaved families or carers for patients who died during Q3 include those relating to medication issues, pressure care, pain management, delays with procedures such as catheterisation and investigations, falls, communication, issues around deterioration, general lack of care on the wards and shortage of nursing staff, attitude of nursing staff and lack of privacy, lack of follow-up care, language issues, concerns around discharge and corridor care in ED.

6.0 Learning to Improvement

6.1 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.

6.2 Learning is disseminated to relevant internal and external stakeholders and, where appropriate, is incorporated into existing improvement programmes of work within the organisation including those relevant to the Trust PSIRF Priorities.

6.3 The top 4 problems in care as identified by SJR reviewers during Q3 are:

1. Problems leading to admission or readmission, including transfer decision, admission avoidance, escalation planning and/or planning for admission avoidance.

   Two broad themes have been identified in this category – issues with previous admission or discharge, and long waits in the ED due to the lack of medical bed availability and failed discharge. Additional learning identified around issues including ReSPECT forms - their availability in the home environment to facilitate preferred place of death, or where delays in ED have resulted in delayed completion of the ReSPECT form, missed opportunity to review imaging which may have facilitated earlier clinical review post-discharge, and management of insulin therapy during previous admission and subsequent readmission with hypoglycaemia.

2. Problems related to initial or ongoing treatment and management plan including preventative strategies (including falls, pressure damage or venous thromboembolism).

   Themes within this category related largely to escalation and management plans, including management of high National Early Warning Score 2 (NEWS 2) including handover to weekend teams, potential for earlier ITU involvement when NEWS 2 is high, monitoring for cardiac arrythmia, incorrect NEWS 2 monitoring and possible missed deterioration, pain management for palliative care, delays with cross-site transfer, management of malignant ascites, delays obtaining pressure-relieving mattresses, obtaining appropriate senior advice regarding antibiotic therapy, sepsis screening and delayed antibiotic administration, lack of availability of medical beds resulting in the provision of End-of-Life care in ED.

3. Problems in communication with relatives and carers

   Themes within this category incorporated learning around family involvement with the completion of ReSPECT forms and communication with families during admission and when patients are deteriorating, misidentification of next-of-kin, and communication around the death of a loved one.

4. Problem in initial assessment, investigation, or diagnosis including assessment of pressure ulcer risk, VTE risk, and history of falls:

   Learning identified within this category can be themed into initial diagnosis and management plans, cross site / referral pathways and inappropriate hospital site or clinical area. This includes issues around medical clerking, initiation of appropriate imaging, delayed thrombolysis, electronic documentation during initial diagnosis, referral pathways within urology involving delays in ED and cross-site transfer, delayed medical reviews and corridor care and use of 'Fit to Sit' area in ED.

6.4 Other common themes identified within the wider Learning from Deaths agenda remain consistent with previous quarters and relate to the provision of End-of-Life care especially with regard to early recognition of dying and decisions to withdraw care, completion of SWAN pathway, and pain management, medication issues including documentation of omitted doses, nursing documentation, nutrition and fluid management, delays with follow-up, surveillance scans and reporting timeframes, missed opportunities for earlier diagnosis, multiple ward moves, delayed ambulance pickups, and corridor care in ED.

7.0 Maternal Mortality

7.1 During Q3, there were no maternal deaths reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

8.0 Paediatric Mortality

8.1 There were 7 paediatric deaths across the Shropshire, Telford and Wrekin Integrated Care System (STW ICS) notified through the Child Death Overview Panel (CDOP) during Q3. One of these was an early neonatal death which has been detailed at section 9 of this report, and 2 of these occurred in the ED within the Trust. All child deaths are reviewed within the CDOP statutory process which identifies both positive and negative learning for improvement.

8.2 Positive learning identified through the CDOP panel and received during Q3 includes:

- Provision of good support to facilitate preferred place of death.
- Good support from the paediatric ward and home oncology team.
- Community referrals appropriately made and acted upon.
- Frequent review of the Advanced Care Plan and open access to the ward.
- Excellent communication links established between Acorns Children's Hospice and the community children's nurses providing palliative care.
- Early involvement of palliative care team facilitated by Birmingham Children's Hospital, which supported SaTH and the community team.

Learning for improvement identified through the CDOP panel and received during Q3 includes:

- Requirement for improved communication between Birmingham Children's Hospital and the Trust prior to discharge of a child.

- Delays noted in uploading the Child Death Summary to the Clinical Portal.
- Need for early SUDIC (Sudden and Unexpected Death in Childhood) referrals / discussions.
- Lack of identified keyworker for mortality at SaTH. Funding has been secured for this post and a Job Description is being developed.
- Lack of dietetic support at SaTH necessitating transfer of a patient to Birmingham Children's Hospital for Total Parenteral Nutrition (method of feeding that provides nutrients directly into a vein). A peer review is planned for completion within 12 months and to additionally include the lack of Physiotherapy and Occupational Therapy.
- Lack of children's palliative care provision in Shropshire.

9.0 Perinatal Mortality

9.1 During Q3, there was 1 early neonatal death which met the criteria for MBRRACE-UK reporting. There were 3 stillbirths over 24 weeks gestation but no late fetal losses between 22+0 and 23+6 weeks of pregnancy. Stillbirths 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.

9.2 The main learning point from a completed PMRT review during Q3 related to missed opportunities to optimise the outcome with the use of steroids and magnesium sulphate, prior to the birth of a baby born at 23 weeks gestation. This was not thought to have negatively impacted on the outcome for the baby.

9.3 The MBRRACE-UK report 'Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2022' has been published. The report was discussed at the Maternity Governance forum in December and at the quarterly Maternity and Neonatal Mortality and Morbidity meeting in January 2025. It had been anticipated that an update would be provided in this report however this is now planned for Q4.

9.4 The action plan relating to 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, continues to be monitored through the Maternity and Neonatal Transformation Assurance Committee and as such, reported directly to Board by the Division.

9.5 One of the 3 deaths deemed more likely than not due to problems in healthcare which are detailed at section 11 of this report, relates to a neonatal death that occurred during 2024.

10.0 Deaths of Patients with a Confirmed Learning Disability (LD), Autism or a Serious Mental Illness (SMI)

10.1 During Q3:

- 5 patients died within the Trust with a confirmed LD or autism. One of these cases had an address outside of England so did not meet the criteria for referral to LeDeR.
- 1 patient died within the Trust with a confirmed SMI.

10.2 All deaths occurring within the Trust where it is identified the patient had a confirmed LD, autism or a serious mental illness, receive a mandated SJR by a clinical SJR reviewer in the first instance. Focused support for this process is subsequently invited from the relevant specialist nurses in the Trust to maximise learning opportunities for this group

of vulnerable patients. Whilst there is a Mental Health Clinical Nurse Specialist in post to provide input with SJRs for patients with an SMI, there has been a vacancy for a specialist to support SJRs for patient with a LD or autism.

10.3 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.

11.0 Deaths Deemed More Likely Than Not Due to Problems in Healthcare

11.1 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).

11.2 Following the conclusion of relevant case investigations, 3 deaths are reported to the Board in this quarter which have been 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.

12.0 Getting to Good Project Closure

12.1 The Learning from Deaths improvement project was incorporated into the Trust 'Getting to Good' Programme in 2021. The extensive programme of improvement work arising from this project has been supported by the Trust Project Management Office (PMO) with Executive oversight through the Operational Delivery Group (ODG).

12.2 Following a presentation to the ODG in January 2025, which incorporated a summary of the key benefits realised through the project, various stakeholder testimonies and details of 'lessons learnt', the project has been formally closed with sign off provided by the Executive Medical Director.

12.3 Key benefits realised and evidenced through the programme of work since 2021 as presented to ODG in January include:

- Full establishment of a standardised mortality review process using an online SJR platform developed by NHS England (NHSE). This replaced a paper-based 'CESDI' form which focused on preventability not learning.
- Achieved and sustained NHSE recommendation to review 15% of all deaths using SJR methodology to provide sufficient data to identify and monitor themes and trends of learning for improved patient care. Majority of cases are reviewed within 8 weeks of the death. A 'pool' of reviewers has been established promoting standardisation and quality of review. Learning collated and shared across the organisation and the wider ICB, supporting the wider PSIRF agenda across the organisation.
- Introduction of random selection for SJRs providing 'unknown unknown' learning and a balanced case selection for the review of care.

- Establishment of a weekly Mortality Triangulation Group (MTG), providing oversight of all inpatient and ED deaths across the Trust, an understanding of what is 'normal' for SaTH, identification of triangulated learning with a thematic focus, prompt recognition and dissemination of learning to both internal and external stakeholders, identification of previously unreported patient safety incidents, a 'one case one review' approach to minimise duplication, and an active and committed support to facilitate learning from excellence.
- Development of an online mortality screening tool providing specialty oversight of deaths, with over 3000 submissions from clinical colleagues since the release of the tool in early 2022.
- In collaboration with NHSE, development of a Learning from Deaths Dashboard incorporating key performance indicators relevant to the Learning from Deaths agenda. This is coordinated by the Trust Performance Team and is monitored as a standing agenda item through the Trust Learning from Deaths Group.
- Internal assurance audit undertaken by external auditors identified 'Substantial' Assurance' and described 'robust learning from deaths processes within SaTH'.
- This extensive programme of improvement led to the nomination as a finalist for Patient Safety Team of the Year for a national award.

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 is one Trust-wide risk which impacts on the Learning from Deaths agenda. This relates to the current challenges with the Data Warehouse as detailed at section 3 of this report.

Dr Roger Slater, Trust Senior Clinical Learning from Deaths Lead
Fiona Richards, Head of Learning from Deaths & Clinical Standards
February 2025