The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
14 July 2022

Agenda item	135/22			
Report	How we learn from deaths report			
Executive Lead	Dr John Jones, Acting Medical Director Mr Richard Steyn, Co-Medical Director			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery		Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:** 1,2	
	For assurance	√		
Presented to:	Quality Operational Committee Quality Safety and Assurance Committee			
Executive summary:	This paper provides the Board of Directors with a quarterly update on inpatient and Emergency Department deaths, the Trust's performance in line with national Mortality Key Performance Indicators, a summary of the findings from mortality reviews including a progress report of the new Learning from Deaths process which was introduced on 31 January 2022, an update regarding COVID-19 mortality and a summary of learning that has been identified. In Quarter 3 of 2021/22 there were 484 inpatient deaths and 73 deaths in the Emergency Department. All deaths are independently scrutinised by a Medical Examiner. Just under 13% (target 15-20%) of deaths underwent a case review using the Structured Judgement Review Plus tool (SJRPlus). The CESDI paper-based mortality review form was withdrawn on 31 January 2022. Identified themes and learning are detailed in the report. The Mortality Dashboard is being developed, with assistance from NHSE/I and will require sustainable support from the Trust's Information Technology (IT) team and the Corporate Learning from Deaths team to facilitate successful implementation. A total of 17 of 19 recommendations from the Shropshire Independent Review of Deaths and Serious Incidents (NICHE Phase 2 Review) commissioned by the Shropshire, Telford, and Wrekin Clinical Commissioning Group, are complete.			
Appendix	Appendix 1 - Quarter 3 2021/2022 Medical Examiner (ME) and Bereavement Service report (In Supplementary Information Pack)			
Lead Executive:				

1.0 Introduction

1.1 The National Quality Board (NQB) guidance 'Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (2017)', provides the framework to support the Trust's Learning from Deaths process. All inpatient deaths are scrutinised either by a Medical Examiner or investigated by the Coroner in defined circumstances. Some deaths are subject to further review at speciality level where the review of care delivered to our patients in the days leading up to their death aims to maximise learning opportunities and improve care for our living patients. Patient Safety concerns that are identified during case record review are referred though the Trust Incident Management process for investigation.

1.2 Mortality performance within The Shrewsbury and Telford Hospital NHS Trust is monitored using external CHKS data and through analysis of internal Trust data, which is detailed in the report. Feedback from bereaved families is used to further support this work.

2.0 Update: Learning from Deaths process

2.1 The paper-based mortality review form known locally as the 'CESDI' form was withdrawn from use across the Trust on 31 January 2022. The new Learning from Deaths process which has been operational since this date consists of 3 stages:

1. Scrutiny by the Medical Examiner
2. Mortality screening
3. Mortality review using the online Structured Judgement Review Plus (SJR) tool (available from NHS England/Improvement)

2.2 Coordination of the operational Learning from Deaths process has been centralised through the Trust Mortality Triangulation Group (MTG). This group was established late 2021 to facilitate improved oversight and triangulation of cases for review and ensure that the appropriate pathway to manage individual cases is agreed. It aims to avoid duplication of reviews or investigations, ensure appropriate internal or external referral as required and to facilitate clarity for the bereaved. The group meets on a weekly basis and membership includes: the Learning from Deaths Lead, Trust Medical Learning from Deaths Lead, Head of Legal Services, Assistant Director of Nursing, Quality Governance, and the Medical Examiner Service Manager. Cases within a defined timeframe are discussed in detail where the Medical Examiner has identified potential learning and / or flagged a case for SJR or when a death has been referred to the Coroner. A sub-meeting currently takes place with the Divisional Quality Governance teams following the MTG. Relevant cases are allocated to the Divisional Quality Governance teams for further action and cases can also be escalated from the Divisions to the central Learning from Deaths Lead where operational issues arise. The MTG and sub-MTG meetings are evolving at pace, with the terms of reference, reporting structure and associated meeting templates being developed.

2.3 A new online mortality scrutiny outcome / screening tool has been developed internally and was launched on 31 January 2022 across the Trust. The initial 'pilot' phase is planned to last approximately three months. During this period, feedback will be collated, and it is anticipated a revised version of the forms will be released after this date. Three forms are available to the user: Form 1 ME Scrutiny Outcome Form is used by the Medical Examiner Service only and notifies relevant cases to the Trust Learning from Deaths Lead for discussion at MTG, forms 2 and 3 Screening Forms can be completed by any member of the team who was involved at any point in the care provided to a patient. It provides an opportunity for staff to reflect at the point of care

and flag cases for further review and identify positive or negative learning to influence and inform quality improvement work across the Trust. Cases which are positively screened for SJR using this online tool are coordinated through the Trust MTG.

2.4 The Corporate Learning from Deaths substantive team currently consists of 1 whole time equivalent (WTE) Trust Learning from Deaths (Mortality) Lead and the Trust Medical Learning from Deaths (Mortality) Lead – allocated 1PA (which equates to 4 hours per week). The national and local Learning from Deaths agenda is evolving and developing at speed and the demands of this exceed the capability of the existing resource within the Trust. Work is underway to explore options to increase the size of the Corporate Learning from Deaths team.

2.5 The Trust Learning from Deaths policy requires review to reflect the new processes now in place across the Trust. This is in progress but has been delayed due to the current resource limitations. A 'Policy on a Page' has been published in the interim period.

2.6 Divisional roles and responsibilities to support the Learning from Deaths agenda have been agreed within the new Quality Governance teams established across the Trust. Some medical roles and responsibilities are yet to be defined and confirmed. This is monitored through the Getting to Good programme.

2.7 Standard agenda templates and reporting requirements to support the Learning from Deaths framework within Divisional and Speciality Morbidity and Mortality and Governance meetings require development in collaboration with the Quality Governance teams, to ensure consistency in approach across the Trust.

3.0 Learning from Deaths performance – internal data

3.1 In Q3 2021/2022 there were 557 inpatient and Emergency Department deaths across the Trust. Of these, potential learning was identified in 88 of the cases, 42 SJRs were recommended by the Medical Examiner (ME), a further 9 SJRs were recommended through the Trust Mortality Triangulation Group and an additional 7 SJRs recommended through mortality screening (total 10.2%).

3.2 Mortality Scrutiny and Bereavement feedback summary:

Please see the attached Quarter 3 2021 2022 Medical Examiner (ME) and Bereavement Service report.

3.3 Mortality Screening:

The new online mortality scrutiny outcome / screening tool, which is anticipated to increase the number of cases flagged for SJR within the Trust, was not available in Q3, although since its launch on 31 January 2022 it has been used retrospectively to screen cases which would previously have been managed using the 'CESDI' form. Mortality screening is anticipated to increase the number of cases flagged for SJR over the next 6-12 months as the new Learning from Deaths process embeds across the Trust.

3.4 Summary of online Mortality Scrutiny Outcome / Mortality Screening Form use

The number of submissions since the mortality scrutiny outcome / screening tool was launched on 31 January to 31 March 2022, is summarised below:

	Number of submitted forms	Medical Examiner Scrutiny Outcome Form 1	Screening Forms 2&3
Total forms submitted (31 January to 31 March 2022)	307	94	213

135 of the screening forms 2 and 3 submitted relate to deaths within Q4 2021/2022 of which 14 flagged a case for SJR.

51 of the screening forms 2 and 3 submitted relate to deaths within Q3 2021/2022 of which 7 cases have been flagged for SJR.

27 of the screening forms 2 and 3 submitted relate to deaths Q1 and 2 2021/2022 and cases before these dates. 10 of these have now been flagged for SJR.

The remaining forms have been submitted since 31 January 2022 by the Medical Examiner Service to identify cases for discussion at the MTG.

Several online screening forms completed by clinical teams have flagged the case for SJR based on positive learning to be shared. Examples provided include:

- Family involvement with discussions between ITU and medical team.
- Positive feedback about the provision of End-of-Life care and Chaplaincy Service.
- Excellent continuity of care given by Endocrine Consultants.
- Good examples of shared care between ICU and the parent team.
- Deteriorating patient pathway being used well, with progressive reviews and ICU involvement.
- Regular Consultant input on ward 32.
- Timely recognition of frailty and recent deterioration. Comfort and dignity prioritised. Good communication with next of kin.
- Excellent multi-disciplinary care provided.
- Organ donation was discussed with the family.

The Learning from Deaths team are introducing a process to ensure positive feedback identified through the Learning from Deaths agenda is recognised and provided directly to clinicians involved in the care of individual patients. This will complement existing Learning from Excellence strategies across the Trust.

3.5 Mortality Triangulation group (MTG) update:

Identified learning and emerging themes noted during Q3 include:

- Issues around verification of death including delays in verification being completed – this is a recurrent theme that was also seen in Q2. An ‘Alert’ icon has been developed and is now available on the Learning from Deaths intranet webpage. A specific alert, approved through the Trust Learning from Deaths group has been uploaded to the webpage to raise the profile of this concern. A training programme is also underway to train band 6 nurses to undertake this vital role.
- Delay in ambulance offloads on both sites - all cases where a patient has died and there has been an ambulance offload delay into the Emergency Department are being reviewed by the Head of Clinical Governance using

the SJRPlus in the first instance. Any case where the delay is deemed to have contributed to the outcome, will be referred through the Trust Incident Management process.

- Issues around the discharge of patients out of hospital remains a theme seen through the MTG. Several cases have been identified where concern has been raised relating to a previous failed discharge.
- Fast Track Discharge not being completed - there is ongoing work both within the Trust and involving the wider system to review the utilisation of fast-track pathways. An End of Life / Palliative Care Dashboard is being developed and this will improve Trust wide data collection to support this valuable work.
- End of Life care – specific concerns raised by the bereaved relating to communication around End of Life care decisions as well as delays in communication with the family following the death of their loved one.
- Medical documentation - cases identified where there is no evidence of a 'post-take' ward round review, no medical entries over the Christmas period and no Consultant review for 17 days. These cases will be reviewed within the respective Divisions.
- Cross site transfer issues involving transfer of surgical patients between Princess Royal Hospital and Royal Shrewsbury Hospital and transfer issues relating to patients arriving at the Royal Shrewsbury Hospital with a cardiac complaint and requiring transfer to Princess Royal Hospital.
- Medication issues - following a cluster of cases where a medication incident has been noted through ME Scrutiny, SJR training will be offered to the Trust Medical Safety Officer to support the mortality review process.

3.6 Mortality case reviews:

Both the online SJR and the paper based CESDI form were available to clinicians to complete mortality reviews during Q3 2021/2022 and therefore a summary of both these tools is provided.

In Q3 2021/2022 just under 13% of all deaths within The Shrewsbury and Telford Hospital NHS Trust received a mortality review using the online SJR, an improvement of nearly 8% from Q2. This increase is very encouraging however the table below demonstrates that significant numbers of SJRs recommended by the ME through scrutiny remain outstanding. Monitoring the completion of these must be a priority for Divisions to ensure maximum learning opportunities are identified and acted upon.

Q3 Total deaths (Inpatient and ED)	557
Q3 Total number of deaths flagged for SJR (NHSI recommended target 15-20%)	57 (10.2%)
Q3 Completed mortality reviews (CESDI or SJR) out of the 57 deaths flagged for SJR (to 31 March 2022)	9
Total number of mortality reviews undertaken for all 557 deaths in Q3 to 31 March 2022 (CESDI or SJRPlus)	164 (93 CESDI reviews 72 SJRs)

4.0 Learning from mortality reviews completed within the Trust using the online SJRPlus

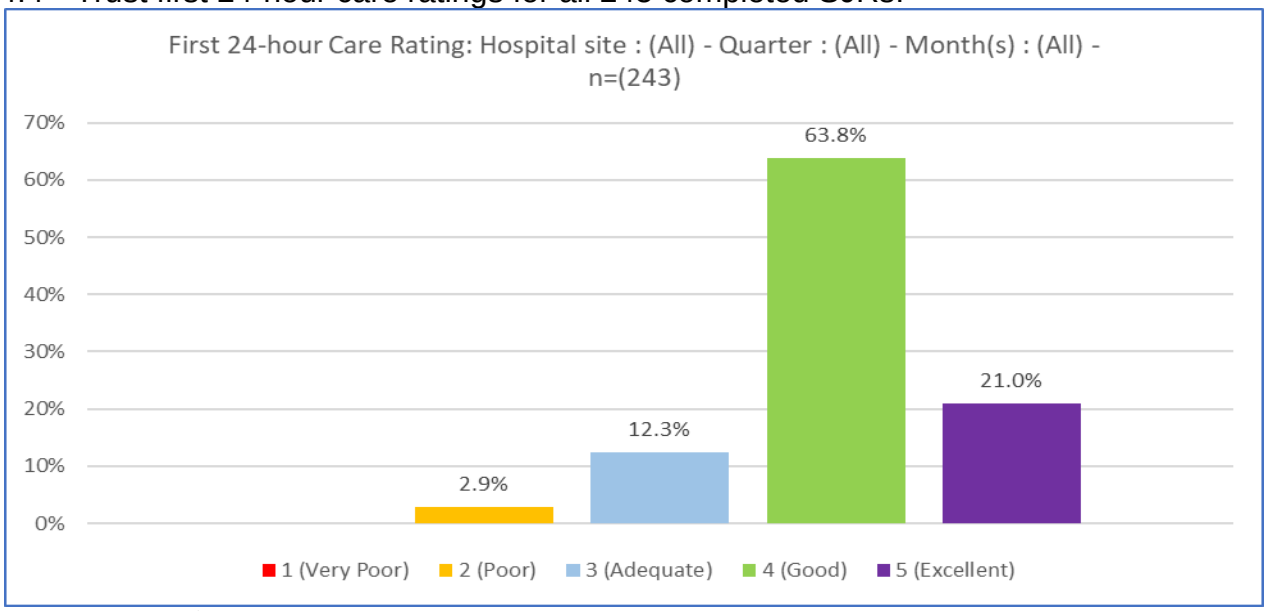
4.1 Reviewing the care provided to a patient leading up to their death aims to identify the wealth of learning opportunities available to improve care for our living patients. The online SJRPlus facilitates more detailed analysis of the care provided to the patients

who have died within the Trust and where an SJR has been completed. A total of 245 SJRs have now been completed since the online SJRPlus was made available to clinicians in April 2021. The key learning from these is summarised in this section. Additional corporate resource to support the Learning from Deaths agenda will enable more effective utilisation of these reports to influence Quality Improvement work within the Trust.

4.2 SJRs should not be completed by a clinician who was involved in the care of individual patients where possible. However, in some specialties where this may pose a challenge, it is expected that care will undergo a second review to provide an independent perspective.

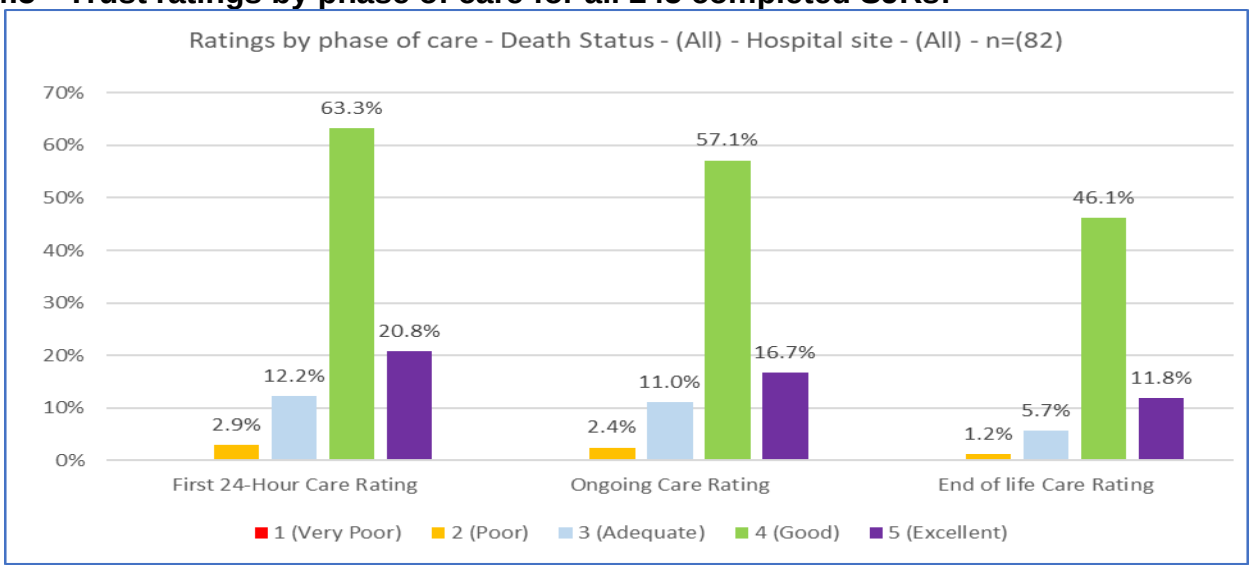
4.3 Of the 245 SJRs completed since 01 April 2021, 199 were for deaths that occurred in the Emergency Department. It is important to recognise therefore the outcomes provided below are weighted towards care provided within the first 24 hours rather than being necessarily representative of care across the Trust throughout all phases of care patients may experience. As the wider use of the online SJR embeds across all Divisions and Specialties, this will improve.

4.4 Trust first 24-hour care ratings for all 245 completed SJRs:



**number of not applicable records 2*

4.5 Trust ratings by phase of care for all 245 completed SJRs:



Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(243)			
	First 24-Hour Care Rating	Ongoing Care Rating	End of life Care Rating
1 (Very Poor)	0.0%	0.0%	0.0%
2 (Poor)	2.9%	2.4%	1.2%
3 (Adequate)	12.2%	11.0%	5.7%
4 (Good)	63.3%	57.1%	46.1%
5 (Excellent)	20.8%	16.7%	11.8%
Grand total	**99.2%**	**87.3%**	**64.9%**

Ratings by phase of care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(243)			
	First 24 hour care	Ongoing care	End of life care
1 (Very Poor)	0	0	0
2 (Poor)	7	6	3
3 (Adequate)	30	27	14
4 (Good)	155	140	113
5 (Excellent)	51	41	29
Grand total	**243**	**214**	**159**

number of not applicable records 2

4.6 Problems with care identified across the Trust:

The chart below identifies the percentage of cases where problems in care were identified. Based on the 245 completed SJRs the highest theme of concern relates to problems with Clinical Monitoring.

Problems with care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(245)

	n.	%
Yes	33	13.5%
No	212	86.5%
Grand Total	**245**	**86.5%**

Ranked order

Problem area	Yes
Problem in Clinical Monitoring	14
Problem with Medication	13
Problem of any other type	13
Problems in Communication	10
Problem related to Operation	8
Problems leading to readmission	8
Problem related to Treatment	8
Problems in Assessment	8
Problems leading to readmission harm	5
Problem with Nutrition	3
Problem with Infection Control	2
Problem in Resuscitation	1

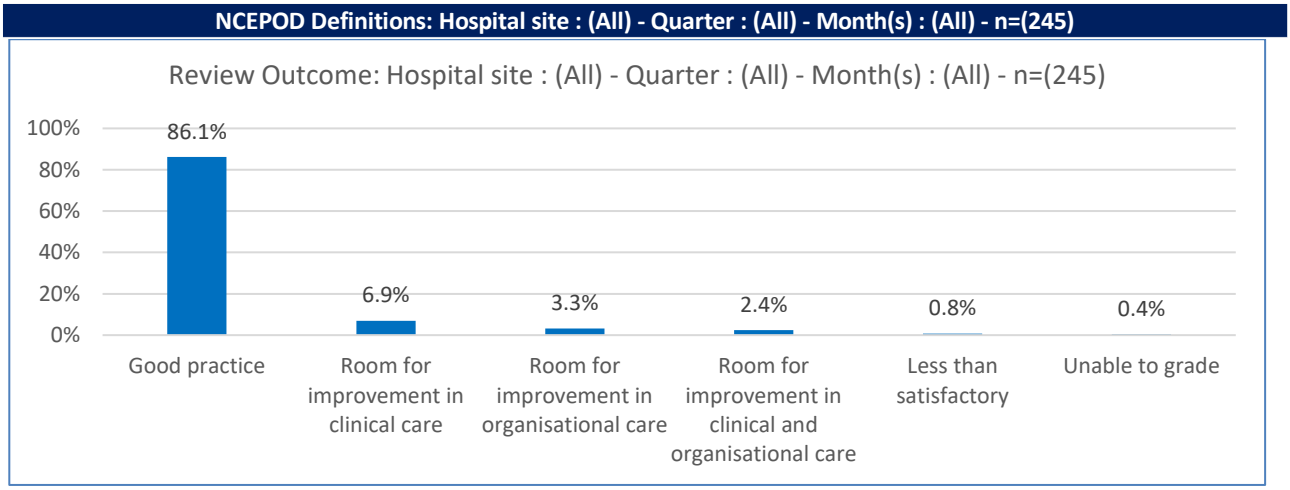
Examples of concerns identified include:

- Prothrombin raised; platelets low - no screening for disseminated intravascular coagulation (DIC). Drop in haemoglobin not investigated

further. Delay in medical review following episode of melena. Medical review not considering increased early warning score, low urine output, hypotension. Despite discussions about suitability for ITU having occurred and a ReSPECT form completed during previous admission, no decision about escalation of care documented or ReSPECT form completed on final admission – previous form not available.

- Failing to act promptly on a recurrent high lactate.
- Need for more detailed assessments and investigations for patients with atypical symptoms.
- Patient not reviewed daily.
- International normalised ratio (INR) not checked on admission. When checked, there was a delay noted in action being taken.
- Symptoms, observations, and investigations suggestive of an alternate diagnosis where a Focussed Assessment with Sonography for Trauma (FAST) scan in Accident and Emergency may have influenced outcome.
- Delay in initiating treatment for sepsis.
- Lack of continuity, ownership and family communication led to long series of investigations, not all of which were appropriate.
- Visiting not facilitated for family despite communication difficulties and frailty.
- Limited medical communication with the family. First discussion documented as one week after admission.
- Lack of timely investigations and treatment.
- ReSPECT form completed in a confused patient without consultation with next of kin.
- Lack of escalation for senior advice.
- Poor documentation during cardio-pulmonary resuscitation.
- Failure to start End of Life care pathway led to confusion when patient was transferred to another ward.
- Direct access issue for surgical patient who should not have gone to the emergency department.
- Earlier initiation of End of Life care pathway needed.

4.7 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ratings: NCEPOD ratings are given for every case reviewed using the SJRPlus tool providing an assessment of the quality of care provided. Over 80% of the 245 cases reviewed are from the Emergency Department and consequently will affect the results seen. Where the need for improvements have been identified, further review is required to identify how these will influence wider improvement work within the Trust.



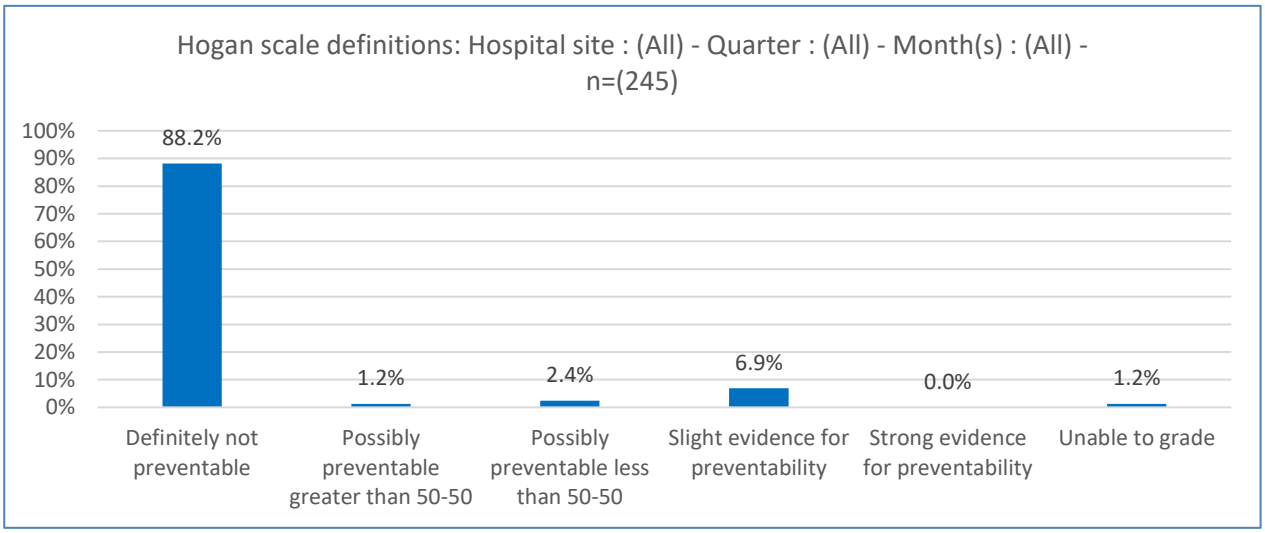
4.8 Deaths where some element of preventability has been determined:

Research suggests that about 10% of deaths may have some element of avoidability / preventability (Hogan et al 2015). The mortality review process aims to collate both negative and positive learning to improve care and facilitate the identification of themes and trends within the Trust rather than a primary focus on preventability. However, there will be occasions when in the judgement of the reviewer the case may warrant further review via the Trust Incident Management process when it has not been previously identified through other processes for example, Datix submitted at the point of care. In these cases, it is expected that an incident will be logged on the Trust Datix system to trigger appropriate referral for investigation and the Divisional Quality Governance teams will then assume responsibility for the case.

Using the CESDI tool the trigger for referral through the Trust Incident Management process has been determined by a score of 2 or 3. In Q3 2021/2022, one case was awarded a CESDI 2 (suboptimal care – different care might have made a difference) and this has been referred to the appropriate Division for further action. There were no cases awarded a CESDI 3 score (suboptimal care, would reasonably be expected to have made a difference).

Within the new Learning from Deaths process, consideration of cases to be referred through the Trust Incident Management process following the completion of an SJR is expected to be undertaken following discussion within Divisional / Speciality Governance and Mortality and Morbidity (M&M) meetings. Further work is required both within the Corporate Learning from Deaths 'team' and within the Divisions to refine this process and ensure a robust framework is in place.

The following chart provides an overview of the percentage of completed SJRs where an element of preventability has been judged by the reviewer. No cases where any element of preventability was rated within the SJR have been reported externally as Serious Incidents within Q3.



4.9 Positive lessons learnt through SJR:
Learning from what has gone well when patients who have died whilst receiving care with the Trust is a vital strategy to improve care for our living patients. The SJR report highlights many instances of positive learning including:

- Examples of good communication within the multi-disciplinary team and with the family.
- Good teamwork.
- Excellent documentation.
- Early involvement of the acute haematology nurse streamlined care and ensure appropriate investigations were undertaken.
- Good family discussions around cardio-pulmonary resuscitation.
- Rapid recognition, management, and appropriate escalation of acutely unwell patient.
- Frailty team reviews.

As the new learning from deaths process embeds across the Trust, it is anticipated that SJRs will be triggered for an increased number of cases where care has been complimented to facilitate replication, as appropriate.

4.10 There is a significant amount of valuable qualitative data available in the SJR report, which is complex to analyse. This poses a sizeable challenge with the current available resource within the Learning from Deaths team. Further work is essential to refine this process and establish the pathway to influence wider Trust improvement plans. Advice to assist appropriate analysis of the report is also being sought from NHSE/I where the report has been developed.

4.11 Work is underway within the Trust to plan how this report will support the identification of themes and trends as part of the wider implementation of the Patient Safety Incident Response Framework (PSIRF) within the Trust although confirmation of the appropriate timescales for implementation from the Patient Safety Specialist Team are not yet available and are dependent on national directives.

5.0 Cases which have been referred through Trust Incident Management Process
On completion of mortality reviews, appropriate referral of cases through the Trust Incident Management process may be triggered. Using the CESDI tool this has been

determined by a score of 2 or 3. The SJR criteria is determined following recognition of any harm, by provision of a Hogan score relating to preventability and the NCEPOD rating relating to quality of care. These will be judged by the reviewer, and it is expected that any referral of cases following SJR through the Trust clinical incident management process will be undertaken following discussion within Divisional / Speciality Governance and Mortality and Morbidity (M&M) meetings. An assessment will be made through this process to determine if the threshold for reporting the case as an external Serious Incident has been met.

5.1 Serious incidents in Q3 2021/2022 relating to patients who have died in the Trust:
There have been 12 serious incidents (SI's) reported to StEIS (Strategic Executive Information System) in Q3 involving the death of a patient who received care within the Trust. Comprehensive investigations into each SI are undertaken with lessons learned and recommended actions identified. All SI's are commissioned through RALIG (Review, Action and Learning from Incident Group), which is a multi-disciplinary and cross Divisional group chaired by the Medical Director. This would include any incident that has resulted in death where there is a cause for concern. Completed investigations are presented to the Group with key findings, root cause and lessons learned. Learning from RALIG, which includes any SI where death is a result is shared through Quality Operational Committee and Quality and Safety Assurance Group monthly incident management report and through the quarterly learning report. Learning is also shared with the Board of Directors.

6.0 Deaths of patients with confirmed learning disabilities

During Q3 2021/2022 there were two deaths of patients with a confirmed learning disability. One of these cases has undergone a mortality review using the CESDI form and no concerns were raised. This case has also been reviewed externally through the LeDeR process (Learning from Deaths of people with a Learning Disability).
A mortality review is currently in progress for the second case and a referral to LeDeR has been completed.

Recent informal feedback from the external LeDeR reviewer during a visit in March 2022 to review the care provided to patients who have died with a confirmed learning disability has been very positive. Emphasis was placed on the quality of support provided by the Acute Liaison Learning Disability Nurse with specific reference to the patients being seen in a timely manner - normally within 1-2 days of admission, evidence of continued face to face follow up was noted and good working with families / care homes and agencies was apparent in the documentation. Referrals to other agencies were deemed to be acted on promptly and it was felt that the acute liaison nurses have a strong presence in the patient's care and are listened to as part of the wider multi-disciplinary team.

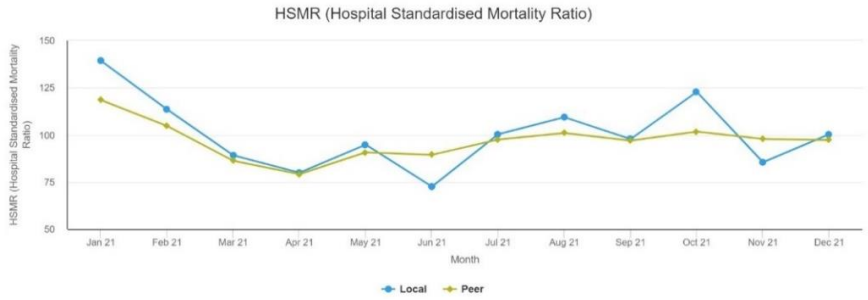
7.0 Learning from Deaths Performance - CHKS

7.1 No Dr Foster Imperial alerts have been received during Q3 2021/2022.

7.2 HSMR - Hospital Standardised Mortality Ratio.
The time series chart 1 below shows the Trust's HSMR performance from January 2021 to October 2021. There has been a recent rebase which brings the mean performance nationally back to 100. The index value has therefore increased for both the Trust and the peer. The rebased model is applied to all historical data resulting in an increased index across all previous months not just the month the rebase occurred.

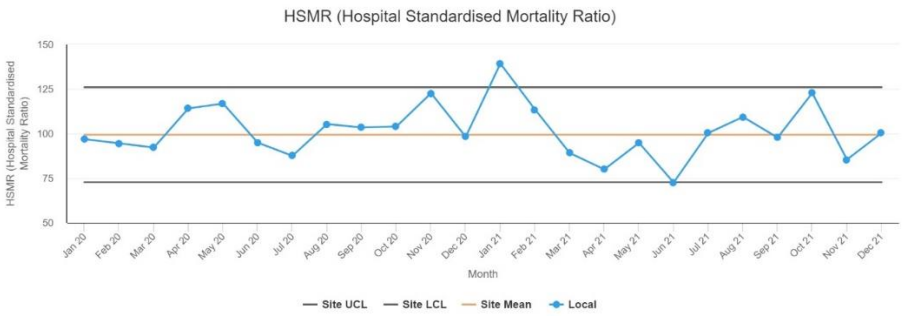
The HSMR index seen in October 2021 is above the peer. The index subsequently decreased for November 2021. It is generally expected to see variation in the HSMR when looking at individual months and a higher index in one month may not be statistically significant. It is therefore usually recommended to review a rolling 12-month figure to facilitate a more robust comparison. This is provided at chart 2 below. The Trust's HSMR long term trend position to this date can be seen to follow a similar pattern to the peer group. The statistical process chart (SPC) chart 3 demonstrates that the HSMR for October 2021 is within the control limits, based on performance over the preceding 2-year period. The high HSMR position in January 2021 correlates to the second wave of Covid-19 deaths.

HSMR time series chart 1



HSMR 12-month rolling time series chart 2

HSMR SPC chart 3



HSMR is adjusted to account for patients with a primary diagnosis of COVID-19 in the first or second episode of care. These patients will be excluded from HSMR. Patients where the COVID-19 coding appears elsewhere in the spell or subsidiary diagnosis, may be included.

7.3 HSMR by condition:

Across both sites, during the period January 2021 to December 2021 the top three conditions where the number of deaths is higher than expected (defined as 'excess deaths') within the HSMR model are:

1. Pneumonia

2. Acute and unspecified renal failure
3. Acute cerebrovascular disease.

This is based on the primary diagnosis code from the first episode of care and does not consider the identified cause of death. All of these were higher than the peer average and an increase from the previous year 2020/2021.

To further support this clinical work, the quality of clinical coding was reviewed as this directly impacts mortality metrics. A process of internal validation is now in place.

7.4 Deaths where pneumonia was the primary diagnosis code:
An audit has been initiated to review the care provided to patients within this cohort. This requires additional resource to complete.

7.5 Deaths where acute and unspecific renal failure was the primary diagnosis code:
An audit has been completed for patients who died within the Trust between September 2020 and August 2021 where acute and unspecified renal failure, which may be referred to by clinicians as acute kidney injury (AKI) was the primary diagnosis code. The results were presented at the Trust Learning from Deaths group in January 2022. Work is now underway with the renal physicians to compliment previous AKI improvement work that been undertaken and to institute an educational update in management of AKI across the Trust.

7.6 Deaths where acute cerebral vascular disease was the primary diagnosis code:
This condition will continue to be monitored and further review work initiated with specialist clinicians to review the stroke pathway over the next quarter.

7.7 Deaths where urinary tract infection was the primary diagnosis code:
An audit has been undertaken to review patients who died during the period September 2020 to August 2021 where the primary diagnosis code was urinary tract infection (UTI). This condition has consistently ranked among the top 3 conditions with the highest number of excess deaths up to this quarter, and it is now the 4th highest condition. The findings were presented at the December Trust Learning from Deaths meeting. As a result, 2 further audits have now been completed to review in more detail cases where:

1. Sepsis was identified as a cause of death – the findings will be presented at the Learning from Deaths meeting April 2022. As a result of the audit, a template is being designed by the Sepsis Practitioners to enable sepsis management of future cases to be validated against a minimum dataset and identify positive and negative learning. This will assist wider sepsis improvement work within the Trust.
2. Cases which involved a readmission to hospital - one case has been referred for a detailed speciality review as the readmission was related to the initial reason for admission. All other cases were found to be unrelated.

7.8 Deaths where cancer of the rectum and anus was the primary diagnosis code:
An initial review into the care provided for patients within this cohort has been undertaken by a specialist clinician following a ‘CUSUM alert’ for this condition during 2021. CUSUM charts show the cumulative difference between observed and ‘expected’ deaths. An increasing trend indicates that there are consistently more deaths than ‘expected’. An alert is triggered when the CUSUM line has breached a confidence limit.

Only 8 patients are within this cohort, 5 of whom had widespread metastatic disease and were receiving chemotherapy. Three patients had surgery all performed by different surgeons. All cases have been discussed during a Governance forum and no themes or specific issues were identified for further investigation.

7.9 Deaths where 'deficiency and anaemia' was the primary diagnosis code:
An initial review into the care provided for patients within this cohort was triggered following a CUSUM alert within the HSMR indicator and as one of the top 3 conditions at RSH with the highest number of excess deaths both in the HSMR and SHMI indicators in December 2021.

The number of patients within this cohort were again small. Widespread comorbidities were found to be associated with the patients, which was considered relevant to the diagnosis of anaemia and to have been expected. The clinicians involved in this small review identified that anaemia is easy to establish from blood results and therefore is likely to be documented on the ward round following admission, although not usually a diagnosis but an indicator of another problem. This will impact mortality metrics.

No specific concerns were raised within the review although the Clinical Coding team will undertake a further audit to determine whether anaemia had been coded correctly for these patients.

This condition will continue to be monitored.

7.10 RAMI – Risk Adjusted Mortality Indicator:
Chart 4 indicates the Trust RAMI performance to December 2021. The indicator remains below the national target of 100, demonstrating performance in the better-than-expected range. The RAMI indicator excludes COVID-19 patients.

The Trust's RAMI position is below the peer average.

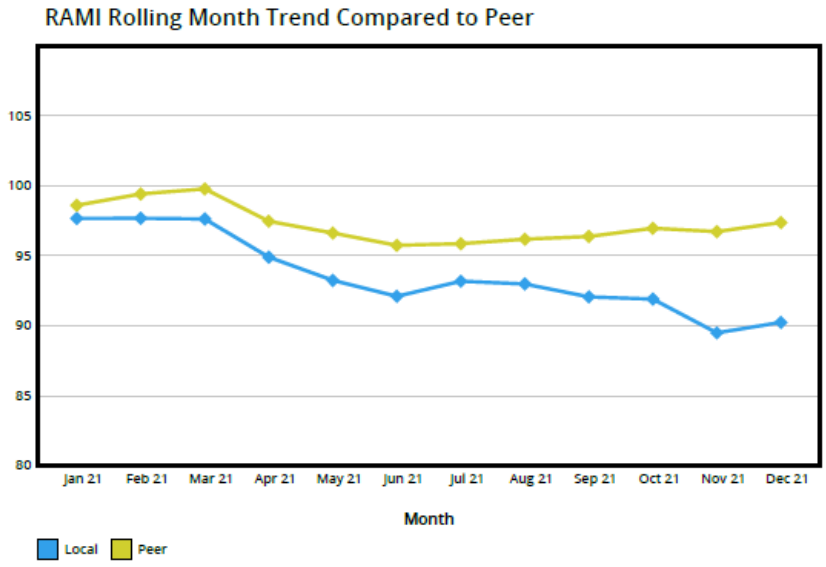


Chart 4

7.11 RAMI by condition:
The top conditions based on the primary diagnosis code where the number of deaths is higher than expected (defined as 'excess deaths') within the RAMI model, are:

1. Pneumonia
2. Acute and unspecified renal failure although septicaemia is now seen as the condition with the second highest number of excess deaths. All except urinary

tract infections have increased from the previous year and, other than pneumonia, were high compared to the peer. The recognition and escalation of sepsis and the deteriorating patient are incorporated within Care Quality Commission (CQC) action plans and Quality Standards.

3. Septicaemia

These conditions have been addressed previously within this report.

7.12 HSMR and RAMI data for admission / attendance on a weekend versus weekday:
The trend for both HSMR and RAMI indicators is higher for admissions and attendances at the weekend versus weekdays however this is a similar trend to the peer. The higher HSMR at PRH for admissions on a weekend versus the peer group continues, however the latest data from CHKS shows a slight improvement. This remains under review and a plan to target mortality reviews for this group of patients is currently in progress.

7.13 SHMI – Summary Hospital-level Mortality Indicator:
SHMI data includes both deaths in hospital and those which occur within 30 days of discharge.

The Trust's SHMI long term trend from the latest available 12-month period up to the end of August 2021 is comparable to the peer average and is shown at chart 5. There has been a decreasing trend in the Trust's SHMI since February 2021.

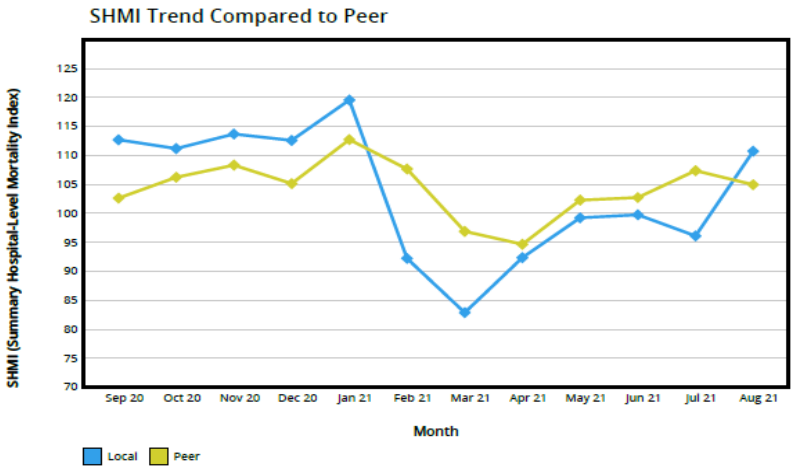


Chart 5

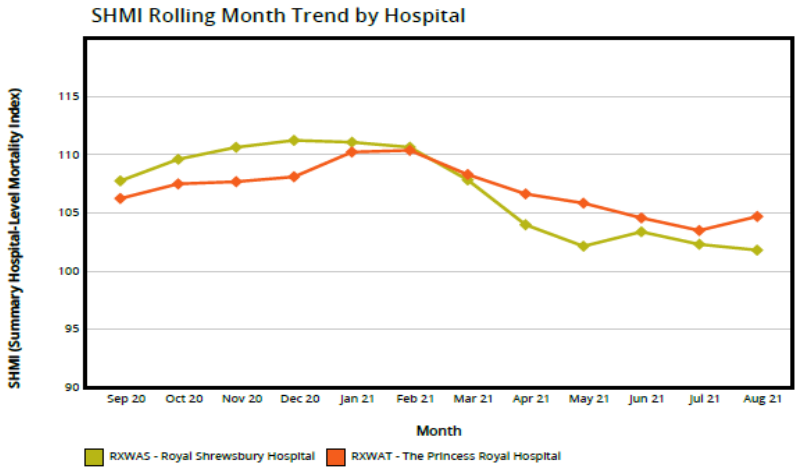


Chart 6

8.0 Learning from Deaths dashboard

The Trust Mortality Lead and the Medical Examiner Service Manager are working with the Trust Informatics Team and NHSE/I to develop the Learning from Deaths dashboard, incorporating both qualitative and quantitative data. Once this is available it will provide valuable insight into various metrics related to the Learning from Deaths agenda to support performance monitoring. How it will integrate with existing performance reports is to be established.

9.0 NICHE recommendations

The NICHE action plan details 19 recommendations relevant to The Shrewsbury and Telford Hospital NHS Trust following publication of the NICHE Independent Review of Deaths and Serious Incidents – Phase 2 report in March 2021. The actions from 17 of these are complete. One outstanding action requires resource from the Data Warehouse team to complete. The other relates to direct access pathways to prevent emergency department admissions. Shropshire, Telford and Wrekin Clinical Commissioning Group (CCG) have been asked to confirm which specific pathways require review. In the meantime, the non-elective pathways programme in the Trust will be reviewing direct access opportunities for patients within the following specialities – gynaecology, paediatrics, head and neck and trauma and orthopaedics. This work is due to commence in October 2022.

10.0 COVID-19 Mortality

10.1 Throughout the first wave, second wave and to the end of February 2022, there have been 145 deaths of patients with probable or definite hospital acquired COVID-19 based on definitions provided by NHSE/I and Public Health England. Of these, 38 were within the Surgical and Cancer Care Division (SACC) and 104 were within the Medicine and Emergency Care Division. All these cases have been uploaded to the National Reporting and Learning System (NRLS). One collective serious incident has been reported which is currently under investigation by the Patient Safety team with support from the Infection Prevention Control team using a combined thematic approach. Duty of Candour is being addressed. Reviewing these deaths collectively is in line with NHSE/I guidance and is an approach adopted by other Trusts.

10.2 A further 35 deaths have been classified as ‘undetermined’ according to the definitions provided by NHSE/I and Public Health England. Families are being approached as part of the formal Duty of Candour process and the Infection Prevention Control (IPC) teams have linked these patients to identified outbreaks within the Trust.

Trust Medical Learning from Deaths (Mortality) Lead
Trust Learning from Deaths (Mortality) Lead
April 2022