The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting
10 November 2022

Agenda item	221/22			
Report Title	How we Learn from Deaths Quarter 4 Report 2021/2022			
Executive Lead	Dr John Jones Executive Medical Director			
Report Author	Fiona Mcaree			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery		Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance			
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	20.09.22 QOC and 26.10.22 QSAC			
Executive summary:	• In Quarter 4 of 2021/2022 there were 426 inpatient deaths and 70 deaths in the emergency department across both sites. Just under 9.5% (target 15-20%) of deaths underwent a case review using the Structured Judgement Review Plus tool (SJRPlus). • The Trust's SHMI position for the latest available period at the time of writing this report January 2021 to December 2021, is favourable to the peer average. SHMI has now replaced HSMR / RAMI in mortality performance reporting in line with NHSE guidance. • The Learning from Deaths Dashboard has been developed. • In Q4 2021/2022 there were 3 deaths of patients in the Trust with confirmed Learning Disabilities. 3 deaths in Q4 were potentially avoidable. • 18 of 19 recommendations from the NICHE Phase 2 Review are complete. • There is one open risk on the Trust Risk Register relating to recruitment to clinical and non-clinical roles to support Learning from Deaths. Recruitment is in progress. • The Q4 report would usually be presented to the Board of Directors in August. Executive approval was provided to delay the report following resource limitations.			
Appendices	**1.** Quarter 4 2021/2022 Medical Examiner and Bereavement Service report **2.** Examples of Feedback from Bereaved Relatives received in Q4			
Executive Lead				

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 including the Learning from Deaths dashboard, which is detailed in the report. Feedback from bereaved families is used to further support this work.

1.3 The format of the Learning from Deaths report is being reviewed and developed in collaboration with NHS England and the Better Tomorrow National Leads to ensure there is a focus on learning and improvement work that is identified through the Learning from Deaths process in the Trust. It is recognised that there is still work required to achieve this effectively and ensure appropriate triangulation of cases. The report continues to evolve and will be enhanced with the additional resource that has been approved to support the Learning from Deaths programme of work as detailed at section 12 of this paper. A national template for this Board of Directors report is under development and the Learning from Deaths team represent the Trust's interest with this work.

2.0 Mortality data

2.1 Summary of deaths, completed SJRs and mortality screenings in Q4 2021/2022:

Total deaths in Q4	496	Inpatient 426 Emergency Department (ED) 70
Total number SJRs completed for deaths in Q4	61 (9.5%)	Includes: 32 ED deaths – until 31 Jan 2022 all deaths in ED received an SJR. SJRs are now targeted through scrutiny or screening in line with NHSE guidance. 4 SJRs mandated for ambulance offload delays. 18 completed SJRs which were flagged through ME Scrutiny. 7 SJRs completed flagged through other sources including mortality screening.
No. of SJRs flagged through Medical Examiner (ME) Scrutiny	42	15 SJRs were flagged by the ME due to significant concerns raised by the bereaved.
Total mortality screening forms submitted within Q4	189	35 of these were positively screened for SJR. 3 of these cases had already been flagged for SJR by the ME. Cases positively screened may also be managed through sepsis validation

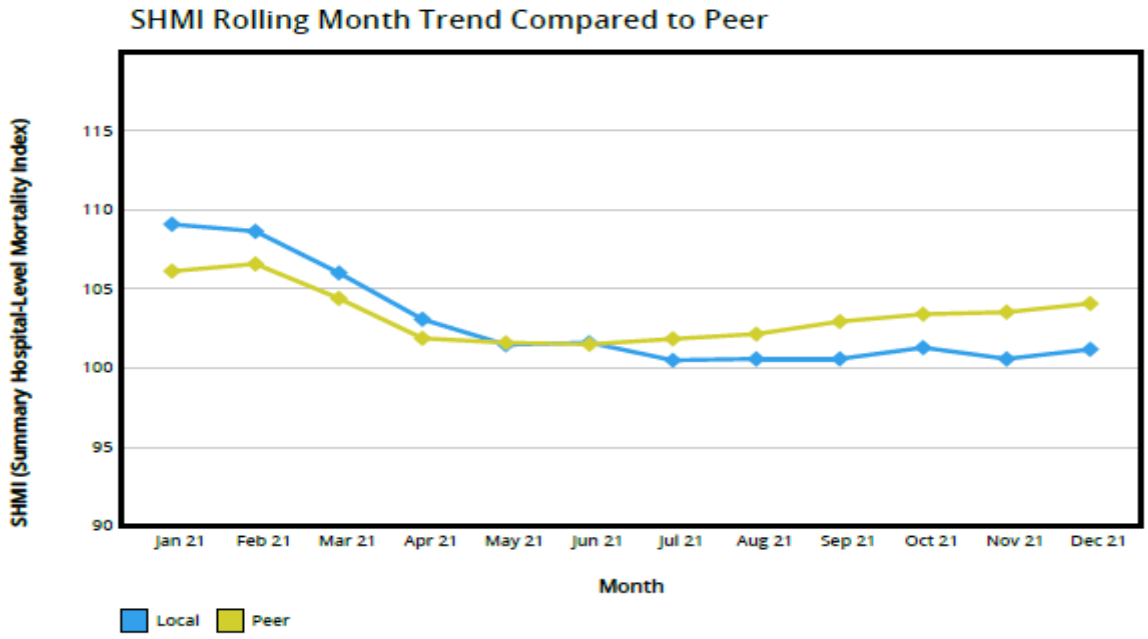
3.0 Learning from Deaths Performance- CHKS

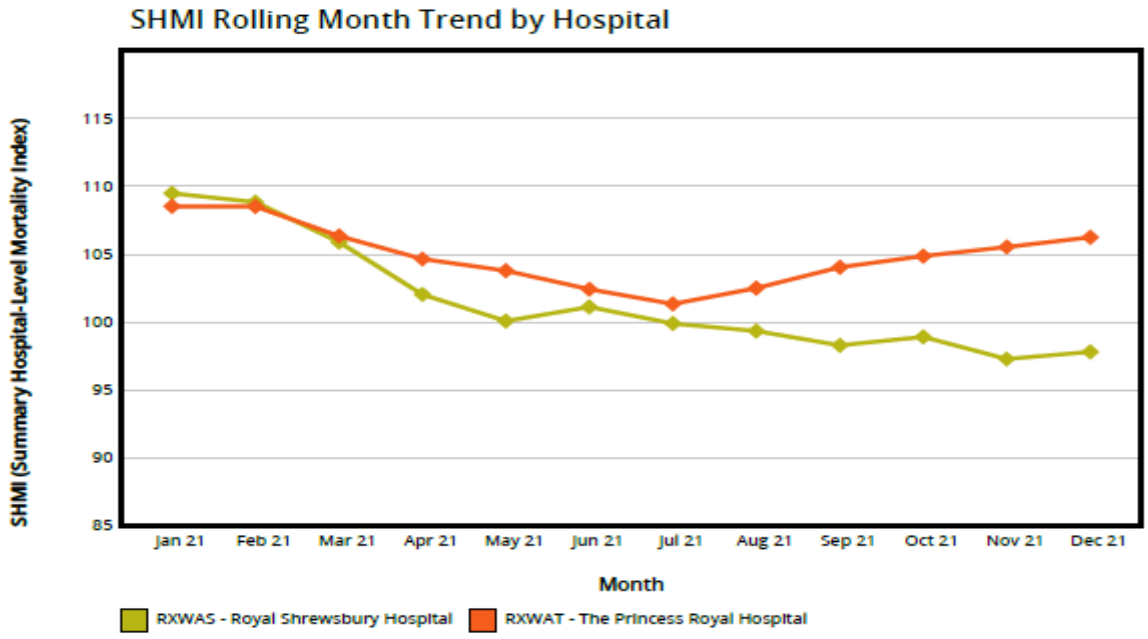
3.1 No Dr Foster Imperial alerts have been received.

3.2 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 position for the latest available period at the time of writing this report January 2021 to December 2021, is favourable to the peer average. The SHMI was higher at PRH than RSH.





3.3 SHMI Details by Condition

The conditions with the highest number of 'excess' deaths are:

- Acute and unspecified renal failure
- Urinary Tract Infection
- Other connective tissue disease

The indices for these conditions were high compared to the peer and had increased from the previous period. SHMI condition groups are assigned based on the primary diagnosis of the first episode of care.

3.4 At RSH the other conditions with the highest numbers of 'excess' deaths were acute and unspecified renal failure and leukaemia, both of which were high compared to the peer although the number of deaths was relatively low for the latter condition.

3.5 At PRH the other highest number of 'excess' deaths were for patients admitted with a primary diagnosis of acute and unspecified renal failure and other connective tissue disease, both of which were high compared to the peer.

3.6 Acute and unspecified renal failure:
Following an audit of patients who died within the Trust between September 2020 and August 2021 where acute and unspecified renal failure was the primary diagnosis code, discussions have taken place with the renal physicians who have now undertaken additional audit work, along with instituting targeted educational activity.

3.7 Urinary Tract Infection (UTI):
UTI is present for both hospitals. Audit work has identified that the management of UTI involves the appropriate institution of the sepsis pathway. This work has resulted in improvements in sepsis training and validation as indicated in section 5.

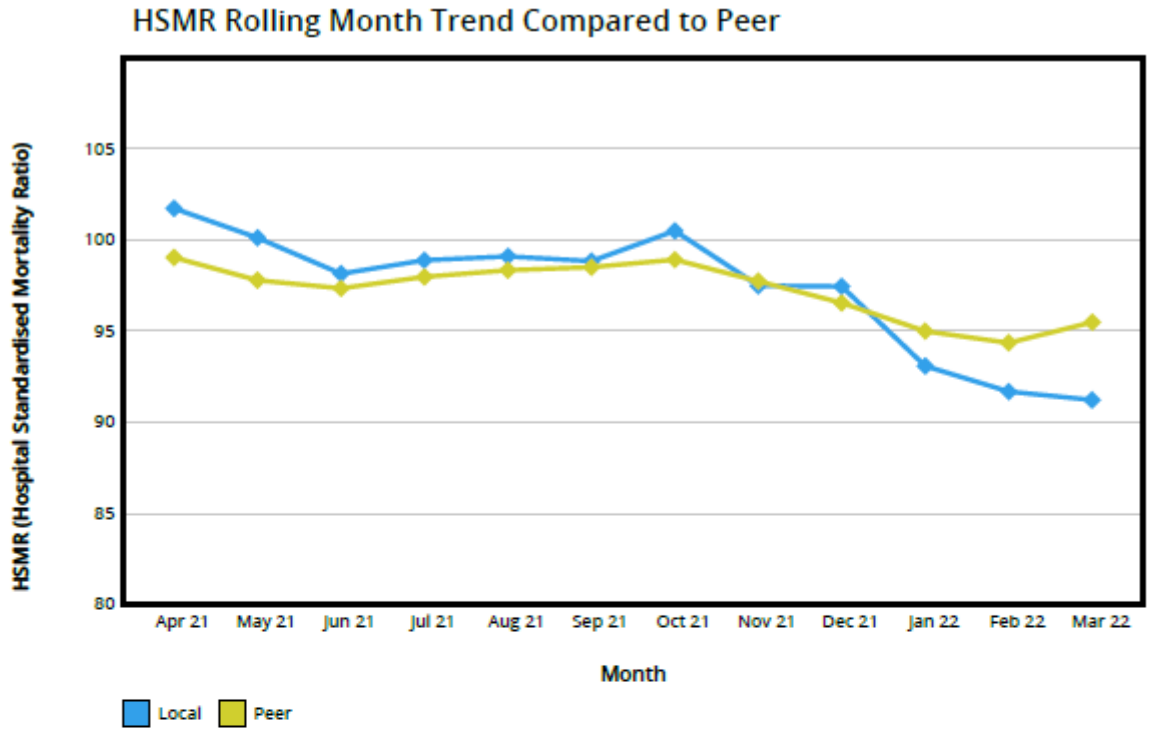
3.8 Other connective tissue disease
Contact has been made with Robert Jones and Agnes Hunt Hospital to initiate further review of these cases although it should be noted, the numbers are relatively small.

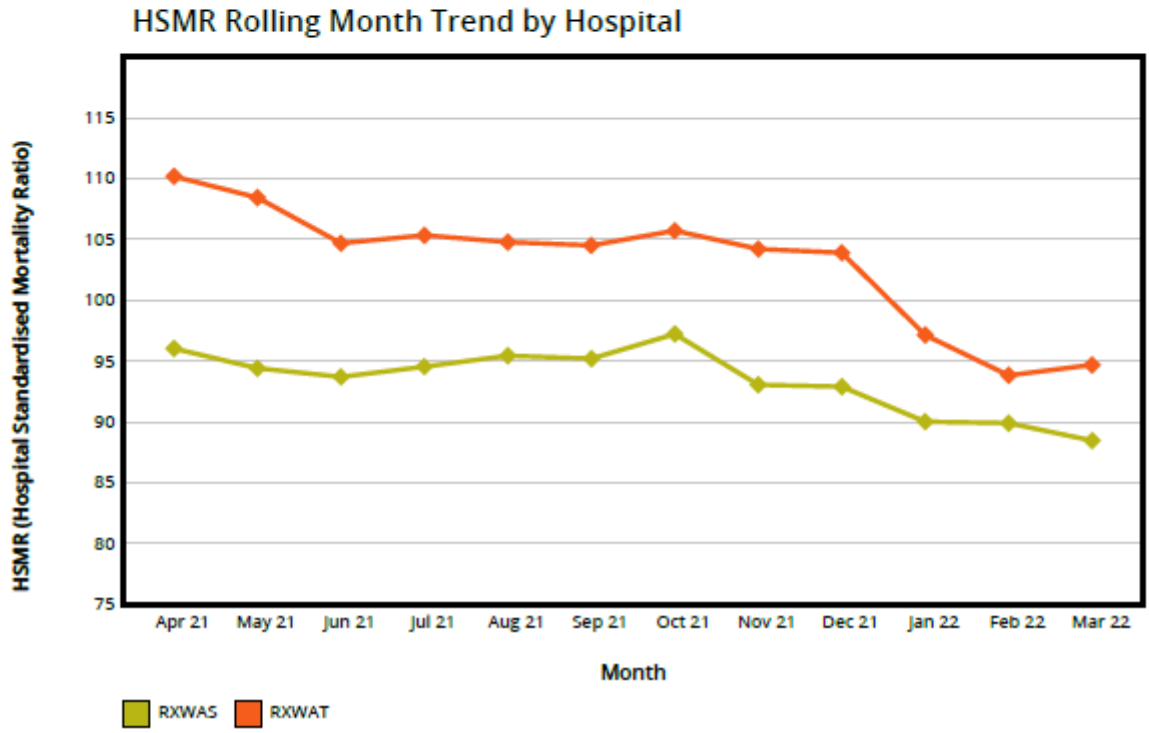
3.9 From September 2022, SHMI data will replace HSMR and RAMI indicators to monitor mortality performance in Learning from Deaths reports and integrated performance monitoring in accordance with NHSE recommendation.

3.10 HSMR - Hospital Standardised Mortality Ratio.

The Trust's HSMR position for the period April 2021 to March 2022 has been lower than the peer average, giving a lower HSMR than the peer for the full twelve-month period. The rolling month chart shows the long-term trend, which follows a similar pattern to the peer.

3.11 The HSMR has reduced for PRH to just below the peer average for the full period.





3.12 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.

3.13 HSMR by condition:

The conditions with the highest number of 'excess' deaths (where there were more deaths than expected by the model) are:

- Acute and unspecified renal failure
- Acute cerebrovascular disease
- Deficiency and other anaemia

All of these were higher than the peer average and increased from the previous year. These condition (CCS) groups are assigned based on the primary diagnosis of the first episode of care.

3.14 Deaths where acute and unspecific renal failure was the primary diagnosis code:

Please see section 3.4

3.15 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.

3.16 Deaths where ‘deficiency and anaemia’ was the primary diagnosis code:

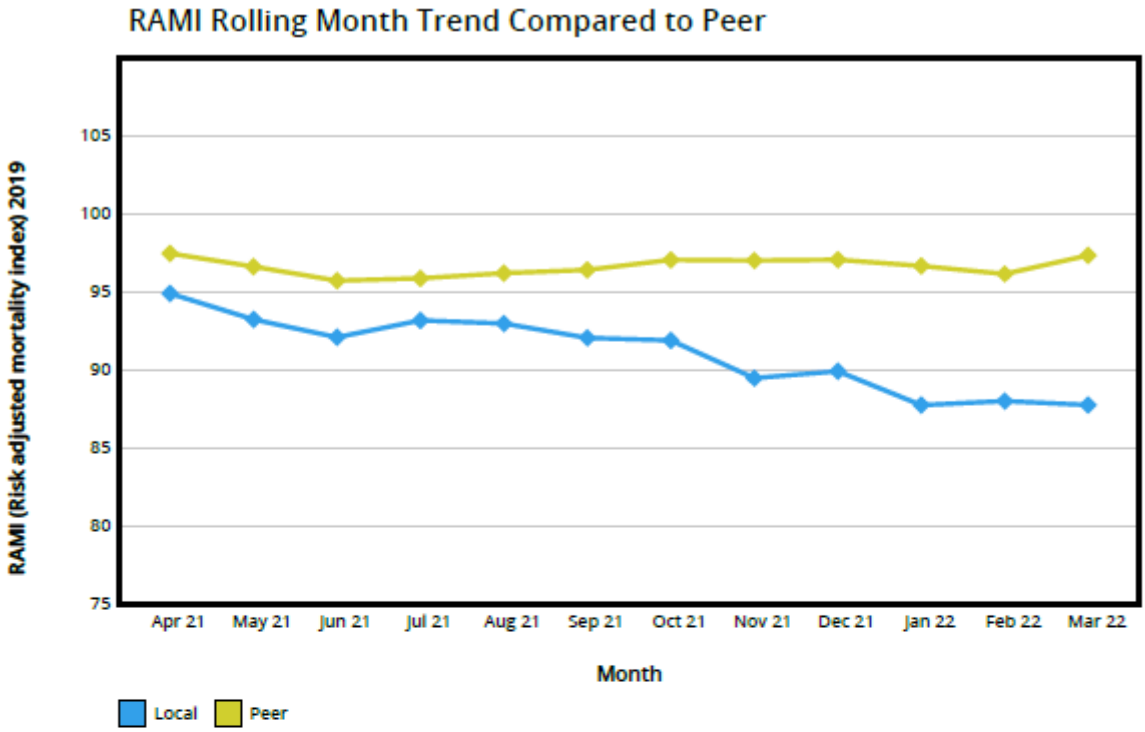
The number of patients within this cohort were again small. Widespread comorbidities were found to be associated with the patients, which was considered relevant to the diagnosis of anaemia and to have been expected. The clinicians involved in this small review identified that anaemia is easy to establish 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.

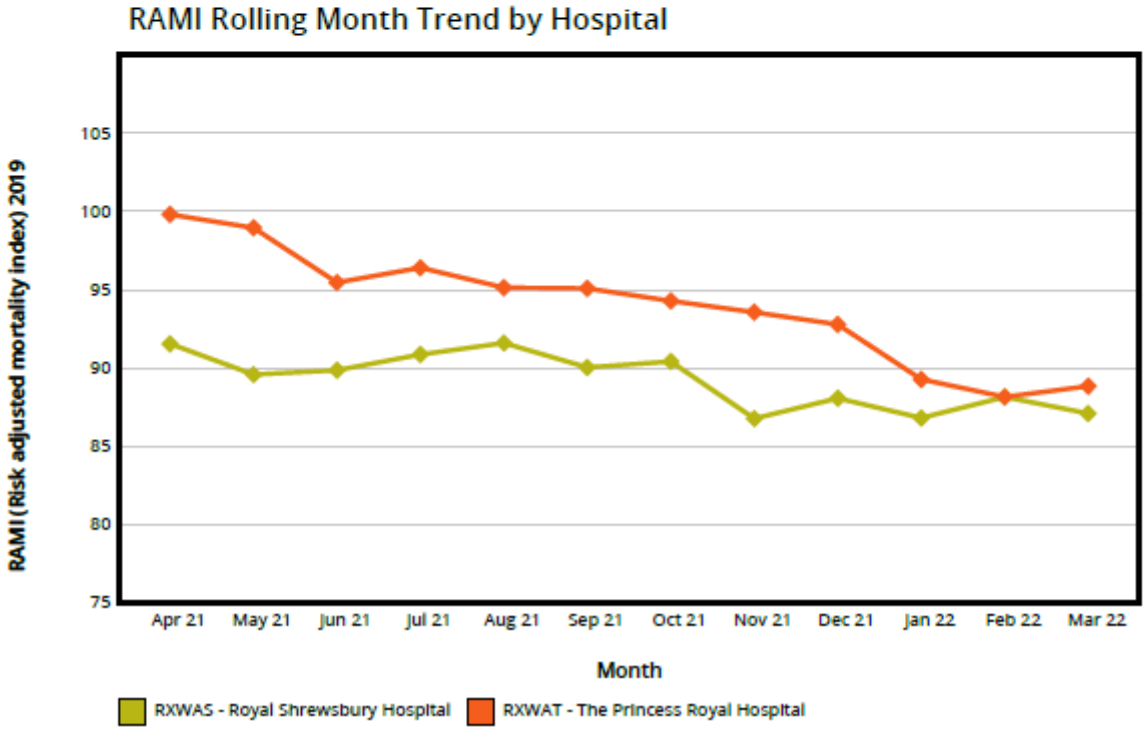
No specific concerns were raised within the review although the Clinical Coding team will undertake a further audit to determine whether anaemia had been coded correctly for these patients.

3.17 At RSH the conditions with the highest 'excess' deaths were acute cerebrovascular disease, deficiency and other anaemia, and pneumonia.
At PRH the conditions highlighted were acute and unspecified renal failure, acute myocardial infarction, and fluid and electrolyte disorders.

3.18 RAMI – Risk Adjusted Mortality Indicator:

The Trust's RAMI position is below the peer average. The index has a decreasing trend for SaTH overall and for PRH. The RAMI indicator excludes Covid-19 patients.





3.19 RAMI by condition:
The conditions with the highest number of 'excess' deaths are:

- Pneumonia
- Acute and unspecified renal failure
- Septicaemia

The index for these conditions had decreased from the previous year, but acute renal failure was high compared to the peer. CCS groups are assigned based on the primary diagnosis of the first episode of care.

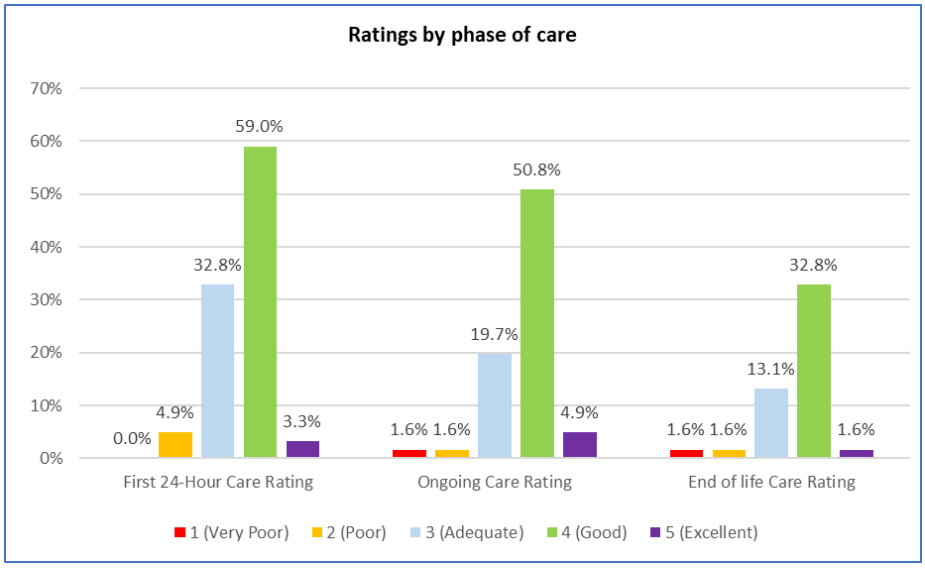
3.20 HSMR and RAMI data for admission / attendance on a weekend versus weekday:

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.

4.0 Care ratings for patients who have died in Q4 and where an SJR has been completed

4.1 The table below provide a summary of the care ratings awarded in the mortality reviews completed using the online SJRPlus. These are divided into:

- First 24 hours of care rating
- Ongoing care rating
- Procedure care rating
- End of Life care rating



4.2 Examples of good / excellent care and positive learning identified:

- Appropriate and timely care, including sepsis management in the ED and Intensive Care Unit (ITU).
- Proactive approach to care from Critical Care and ITU Teams, maintaining family involvement and respecting patient views.
- Good communication with family and involvement with decision making.
- ReSPECT forms in place from the community and updated appropriately in hospital.
- Examples of good nursing, medical and physiotherapy documentation.
- Early initiation of supportive care for a deteriorating patient.
- Good specialist input and treatment plans, including involvement of Mental Health Liaison Team.
- Several examples of good / excellent communication with family members.
- Examples of excellent end of life care and commencement of end-of-life care pathway at an appropriate stage.

- Timely monitoring of cardiac symptoms.

4.3 Seven cases out of the sixty-one completed SJRs were identified as having a care rating of poor or very poor either in one of the phases of care or overall.

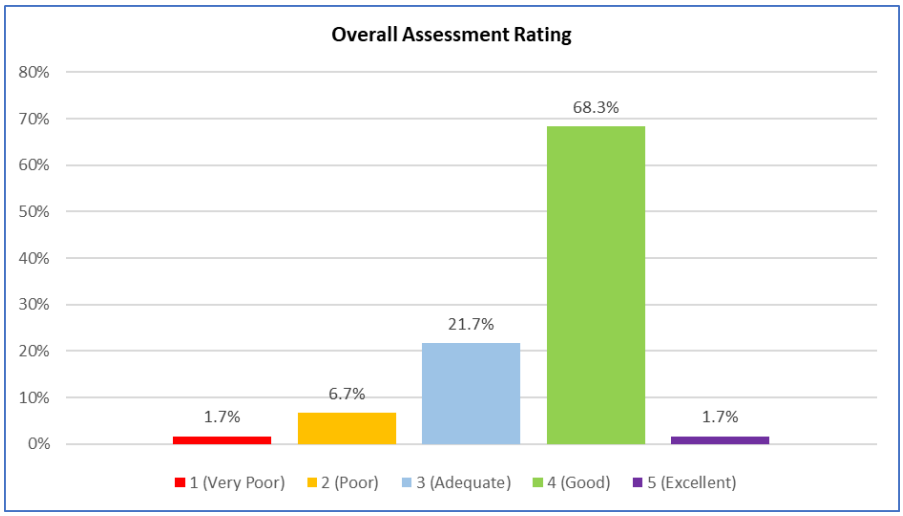
Key learning identified:

- Case 1: Problems identified with utilisation of the acute coronary syndrome pathway and the need to review protocol for diagnosis and treatment was identified.
- Case 2: Delayed institution of end-of-life care which led to initiation of inappropriate treatments. Inconsistency between date of death noted on the Trust Patient Administration System (SEMA) and the date provided in the notes.
- Case 3: Lack of post-discharge follow up arrangements.
- Case 4: Concerns identified around the ward management of sepsis, failure to recognise, escalate and respond to a deteriorating patient and the case was referred as a patient safety incident. Good practice in ED however was noted regarding sepsis screening and treatment.
- Case 5: Six-hour ambulance offload delay into the ED after sustaining a fractured neck of femur – no intravenous fluids or pain relief were provided in the ambulance.
- Case 6: Lack of specialist respiratory beds. Lack of senior support for junior doctors at PRH. Inappropriate use of respiratory support. Poor documentation
- Case 7: Sub-optimal escalation of medical care and organisational problems. with non-invasive ventilation facility at RSH.

4.4 Other negative learning identified includes:

- Lack of timely Consultant assessment.
- Prolonged stay in ED.
- Medication error.
- Lack of daily medical review.
- Sepsis management.
- Sub-optimal documentation including related to discharge.
- Other ambulance offload delays.
- Lack of pain scoring.
- Sub-optimal anticoagulation pathway documentation and management.
- Education deficit regarding Acute Coronary Syndrome.

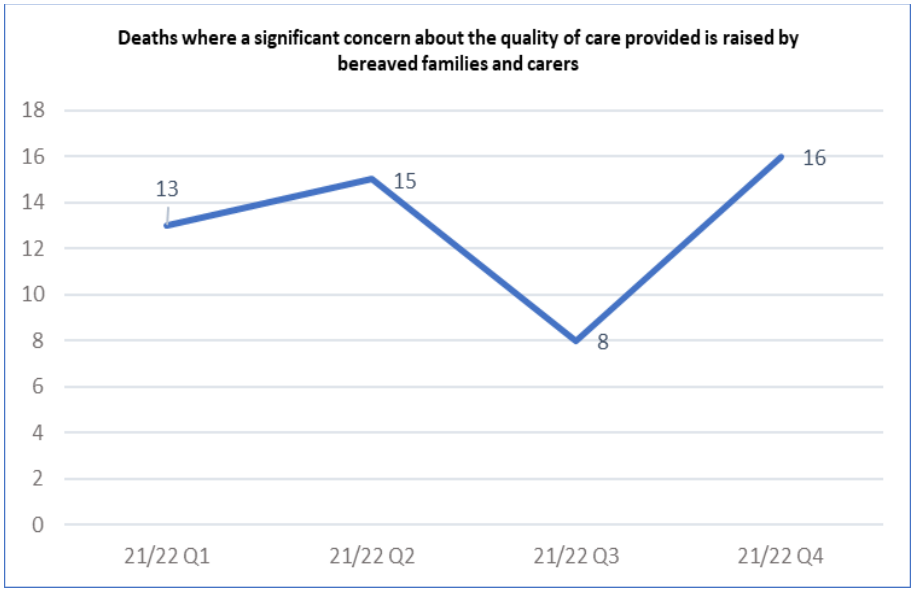
4.5 Overall assessment ratings identified within the completed SJRs are shown in the table below.



4.6 Deaths where significant concerns were raised by the bereaved:

In line with the NQB (2017) guidance, the Trust Learning from Deaths policy recognises the importance of providing bereaved relatives and carers the opportunity to discuss concerns they may have in relation to the quality of care their loved ones received before they died. A one-to-one conversation is offered to relatives as part of routine Medical Examiner Scrutiny and cases are flagged for detailed SJR accordingly. Relatives are also offered the opportunity to complete a Bereavement Feedback Survey – this is described in more detail in the Q4 Medical Examiner and Bereavement Service report at the appendix, where examples of feedback are also provided. Feedback is disseminated to the Divisional teams for action as required.

4.7 In 2021/2022 Q4, 15 cases were referred by the Medical Examiner for an SJR based on significant concerns raised by the bereaved. 16 cases were reported to the National Medical Examiner submission as per chart below however 1 of these SJRs was subsequently identified as being triggered by staff concerns rather than those raised by the bereaved. At the time of writing this report, 6 of these SJRs have been completed.



A formal complaint is in progress for 1 of these cases, 2 cases are awaiting further specialist input and 1 case will be progressed through divisional governance processes.

4.8 SJR Datix, a form within the Incident Reporting Datix module has been developed and went live at the end of May 2022 to assist the management of cases which require further review following completion of the SJR. Inclusion criteria for SJR Datix is detailed within the Trust Learning from Deaths policy.

4.9 It is recognised that the current process to manage the outcome of learning identified through SJRs where the inclusion criteria for SJR Datix completion has been met, is insufficient to guarantee that all the learning has been appropriately managed and disseminated both within divisions and trust wide. Work is in progress to address this through the existing trust-wide and divisional quality governance framework. This will include routine divisional reporting of learning from SJRs, complaints and serious incidents including thematic analysis pertaining to patients who have died, to the Trust Learning from Deaths group and associated governance.

4.10 Work is underway within the Trust to plan how learning identified through the Learning from Deaths process 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. Appropriate timescales for implementation of PSIRF from the Patient Safety Specialist Team are not yet available and are dependent on national directives.

4.11 The completion rate of SJRs within the 8-week timeframe outlined within the Trust Learning from Deaths policy, requires improvement to ensure timely identification of learning and appropriate thematic analysis. The recruitment detailed at section 12 of this paper will assist this when the relevant posts have been filled and are established in role.

5.0 Improvements in care

Management of sepsis and the deteriorating patient, and end-of-life care remain key themes identified through the Learning from Deaths process. Improvement work led by specialist clinicians within the Trust is well established and reported through existing governance processes.

5.1 Sepsis and deteriorating patient improvement work

A sepsis module on CareFlow Vitals (electronic observation and decision support system used within the Trust) has been introduced which prompts sepsis screening and completion of the sepsis bundle.

The specialist sepsis team continue to provide face to face training to nurses, health care assistants, nursing associates and doctors including consultant induction sessions and medical statutory safety updates. An e-Learning sepsis module for both registered and non-registered practitioners has been launched this year and has resulted in a positive impact on sepsis training compliance.

A robust process of sepsis validation has been established within the Learning from Deaths process and this work is positively influencing sepsis improvement work. Cases flagged where sepsis has been a contributory factor in the days leading up to a patient's death are reviewed by the sepsis team specifically to identify any lapses in sepsis management. This scrutiny provides a valuable opportunity to recognise notable practice and may be completed alongside an SJR if indicated. Sepsis

validation also aims to provide assurance that clinicians are reviewing sepsis management appropriately when undertaking case record review and consequently will inform training accordingly.

A programme of audit activity is in place to assess management of the National Early Warning Score (NEWS2) scoring against both the Sepsis Recognition and Management and Deteriorating Patient policies.

An action plan incorporating both short-term and long-term goals has been agreed at the Trust Deteriorating Patient Group to improve deteriorating patient recognition and response, which aligns closely to specific sepsis improvement work in progress.

The Trust has applied to NHS England to contribute to a pilot 'Worry and Concern' trial where concerns from patients and relatives will be incorporated into the assessment and recognition of acute illness and risk of deterioration, to facilitate appropriate escalation in addition to NEWS2 scoring.

New categories for sepsis and the deteriorating patient have been added to the Trust risk management system 'Datix' to assist with the identification of themes and the subsequent planning of improvement work.

5.2 End-of life care improvement work

Improvement work related to end-of-life care is integrated into the relevant Getting to Good programme of work. There has been significant progress with the provision of an end of-life dashboard and system-wide improvement work relating to fast-track discharge of patients to their preferred place of care when they are nearing the end of their life.

6.0 Learning from Deaths Dashboard

6.1 In collaboration with NHSE the development of the Learning from Deaths dashboard has been completed and a schedule for data collation and validation has been developed with the Trust Performance team. The national leads for the NHSE Better Tomorrow 'learning from Deaths, learning for lives' programme facilitated a seminar session for the Trust Board of Directors in July 2022 where there was an opportunity for greater understanding about the dashboard as well as a discussion about the national move to encourage the use of the SHMI indicator published by NHS Digital to replace the routine inclusion of HSMR and RAMI.

6.2 The Learning from Deaths team are reviewing how the dashboard will be incorporated into integrated performance reporting and the operational processes within the Trust.

6.3 The dashboard includes a wide variety of metrics that provide context to the Learning from Deaths agenda including:

- Trust SHMI including observed and expected deaths
- Out of hospital SHMI
- Hospital occupancy
- Coding
- Serious incidents
- SJRs
- Mortality screening
- Learning disability deaths

- Medical Examiner data

6.4 The dashboard will provide divisional and trust-wide transparency regarding SJR completion rates and it is anticipated that appropriate metrics will be incorporated into divisional performance review meetings.

7.0 LeDeR

7.1 In Q4 2021/2022 there have been 3 deaths of people who have died with a learning disability, either as an inpatient or in the ED. These cases have been reported to the service improvement programme for people with a learning disability and autistic people (LeDeR) and have all received an external LeDeR mortality review.

7.2 An internal SJR has been completed additionally for 2 of these patients.

7.3 Positive learning was identified in these reviews including:

- Good communication and the wishes of the patient and family taken into consideration.
- Evidence of holistic review.
- Good end-of-life care provided.
- Involvement of the learning disability liaison nurse.
- Mental Capacity Assessment completed.

8.0 Maternal, Neonatal and Infant mortality

8.1 Nationally, all deaths of pregnant women and women up to one year following the end of the pregnancy irrespective of where or how the woman dies, are notified to MBRRACE-UK – 'Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK'. In Q4 the Trust reported one maternal death to MBRRACE-UK which occurred following a road traffic accident.

8.2 In addition to MBRRACE-UK reporting requirements, all direct or indirect maternal deaths of women while pregnant or within 42 days of the end of the pregnancy are reported to the Healthcare Safety Investigation Branch (HSIB). Direct deaths include those resulting from obstetric complications of the pregnancy, from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these. Indirect deaths include those from previous existing disease that developed during pregnancy, and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of the pregnancy).

8.3 The Perinatal Mortality Review Tool (PMRT) available through MBRRACE-UK is used by the Trust. The tool supports high quality standardised reviews across NHS maternity and neonatal units in England, Scotland and Wales of the care leading up to and surrounding each stillbirth and neonatal death, and the death of babies who die in the post-neonatal period having received neonatal care.

8.4 Perinatal and infant deaths are reported to MBRRACE-UK according to the following criteria:

Term	Definition	SaTH Q4 data
Stillbirths	Baby delivered from 24+0 weeks gestation showing no signs of life	3
Early neonatal deaths	Death of a live born baby (20 weeks gestation or later) occurring before 7 days of life	2
Late neonatal deaths	Death of a live born baby occurring between 7 and 28 completed days after birth	1
Terminations of pregnancy	All terminations of pregnancy after 22+0 and all terminations from 20+0 weeks which resulted in a live birth resulting in a neonatal death	0

8.5 There were no serious incidents relating to maternal or perinatal mortality that were reported to the Strategic Executive Information System (StEIS) during Q4.

9.0 Paediatrics

9.1 There were no deaths of children under the age of 18 either as an inpatient or in the ED in Q4 2021/2022

9.2 One serious incident relating to a child death was reported by the Trust StEIS in Jan 2022. The investigation remains open.

10.0 Potentially avoidable deaths

10.1 A potentially avoidable death is defined within the National Quality Board (2017) guidance as any death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare.

10.2 On completion of the investigation, serious incidents are presented to the Trust Review Actions and Learning from Incidents Group (RALIG), chaired by the Executive Medical Director for approval prior to submission to Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) for final review and approval. Deaths deemed to be potentially avoidable are reported to the Board of Directors once final approval has been provided by the STW ICS to ensure transparency, consistency, and accuracy of reporting. A detailed summary of these cases 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.

10.3 In Q4 2021/2022, 3 deaths within the Trust were deemed to have been potentially avoidable. Duty of Candour is completed by the Divisional Quality Governance Teams.

11.0 NICHE Phase 2 Recommendations

11.1 A total of 18 of the 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 now known as the STW ICS, are complete. These are being monitored through the Getting to Good Programme.

12.0 Risk register

12.1 There is one risk on the Trust Risk Register relating to Learning from Deaths.

12.2 The Trust has agreed to recruit at risk to clinical and non-clinical roles within the core Learning from Deaths team and additional Programmed Activity sessions to support the Learning from Deaths Clinical Lead and completion of SJRs across all specialities. Recruitment is in progress and once the additional resource is in post and fully established, it is anticipated that the risk will close.

Trust Medical Learning from Deaths Lead
Head of Learning from Deaths and Clinical Standards
August 2022

Appendix 1 – Medical Examiner and Bereavement Service Report

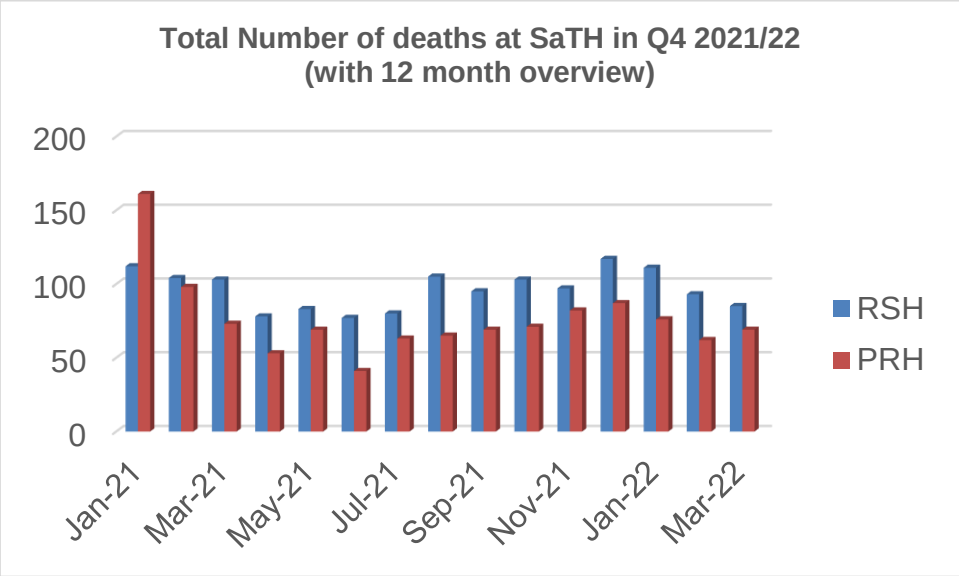
MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT
QUARTER 4 – JANUARY – MARCH 2022

1. Introduction

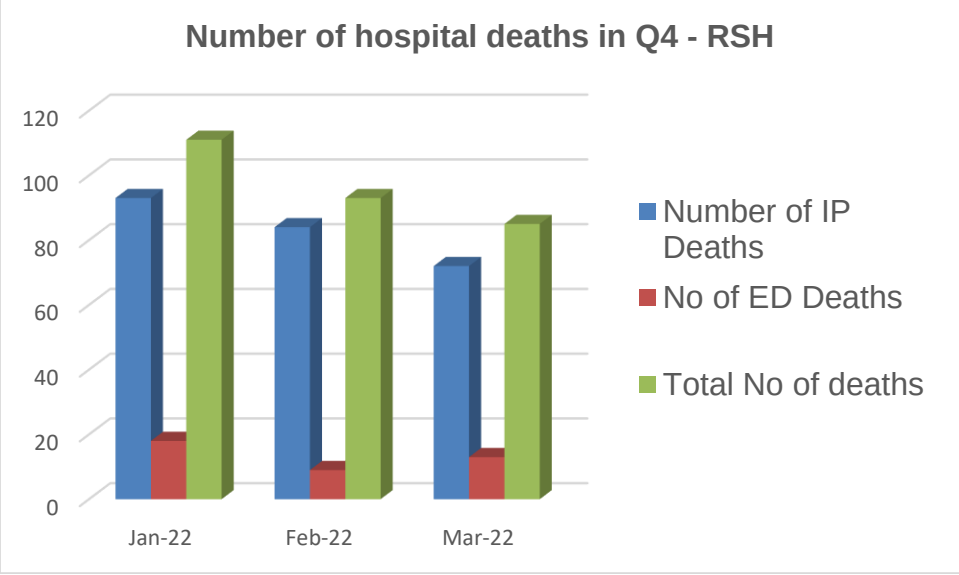
The purpose of this report is to provide the Trust Board with an overview of the hospital deaths managed by the Medical Examiner & Bereavement Service during quarter four (Jan-Mar 2022).

2. Hospital Deaths

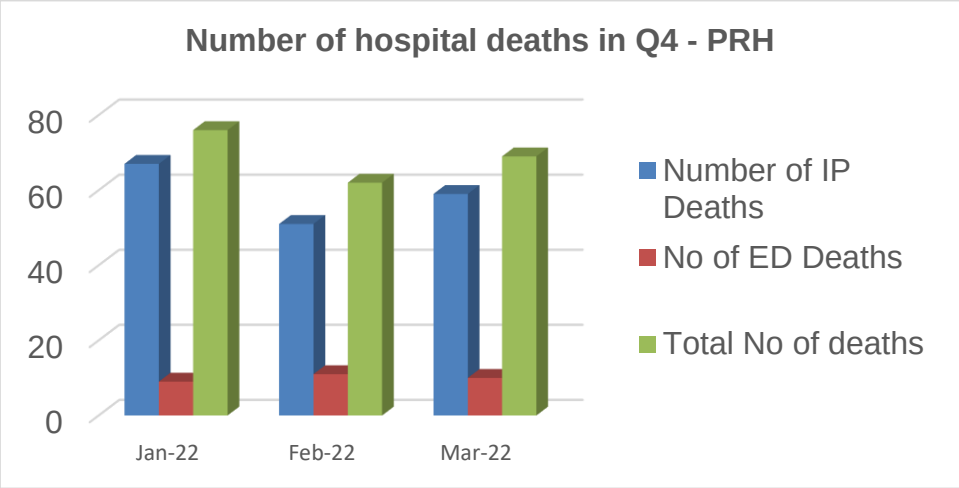
During quarter four, there were 496 deaths across both of our hospitals, which is a decrease of 61 deaths from quarter three of 2021/2022 and a marked reduction of 155 deaths for the same quarter of 2021.



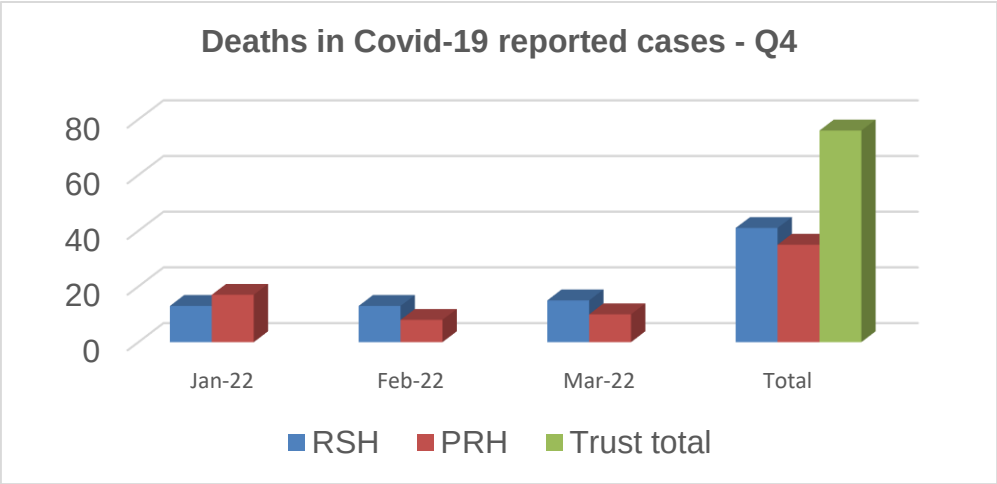
At RSH there were 249 inpatient deaths and 40 deaths in our Emergency Department.



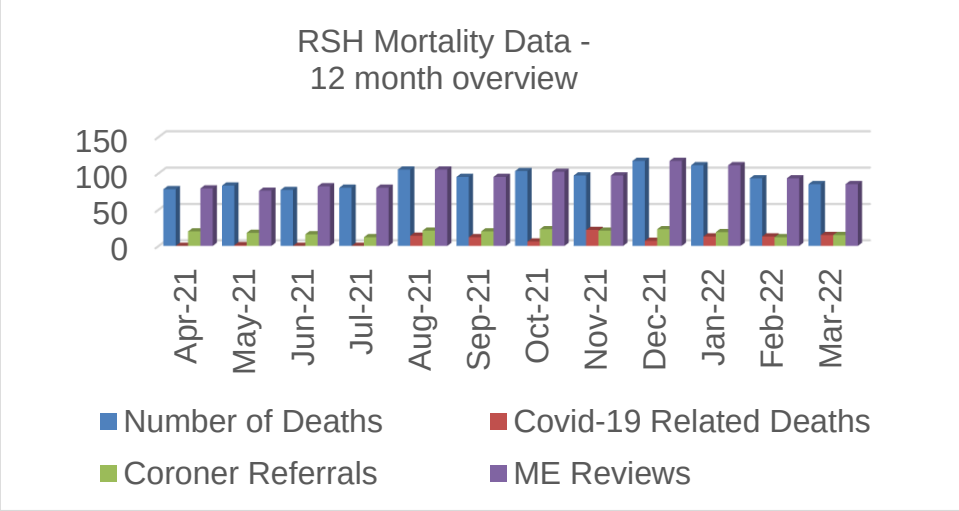
At PRH there were 177 inpatient deaths and 30 deaths in our Emergency Department.

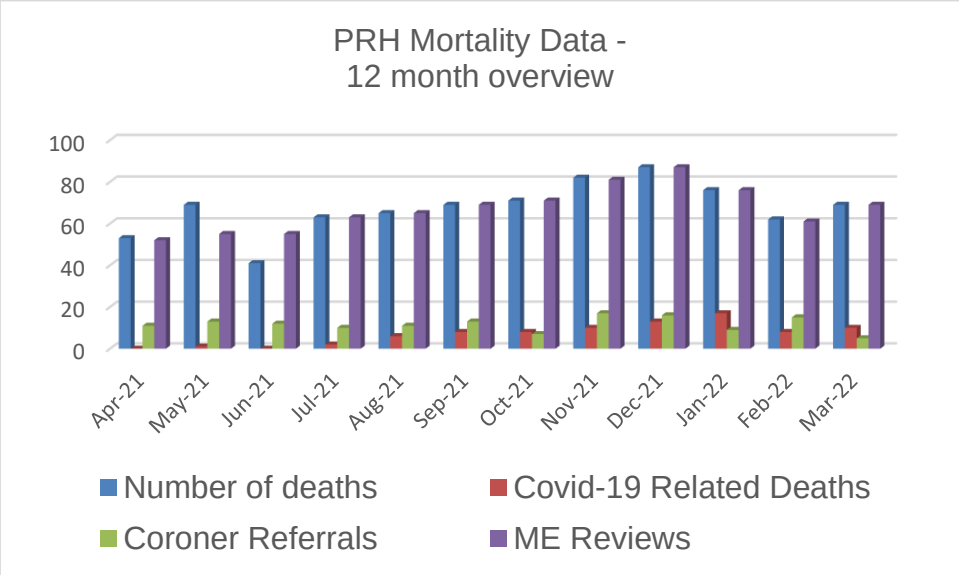


Maintaining review of the impact of the Covid-19 pandemic over the last 2 years, we can see the mortality data for each hospital below for patients who died with a positive PCR result for Covid-19 and whose deaths were reported to NHS England. During quarter four of this financial year 76 Covid-19 related deaths were reported which was an increase of 10 cases from what was reported in quarter three but a significant decrease from the same quarter of the previous year, when 245 Covid-19 related deaths were reported.



The graphs below demonstrate the overall mortality data in terms of the total number of deaths for each site and of that how many referrals were made to the coroner, the activity of the Medical Examiner Service and deaths in patients with a positive Covid-19 PCR.

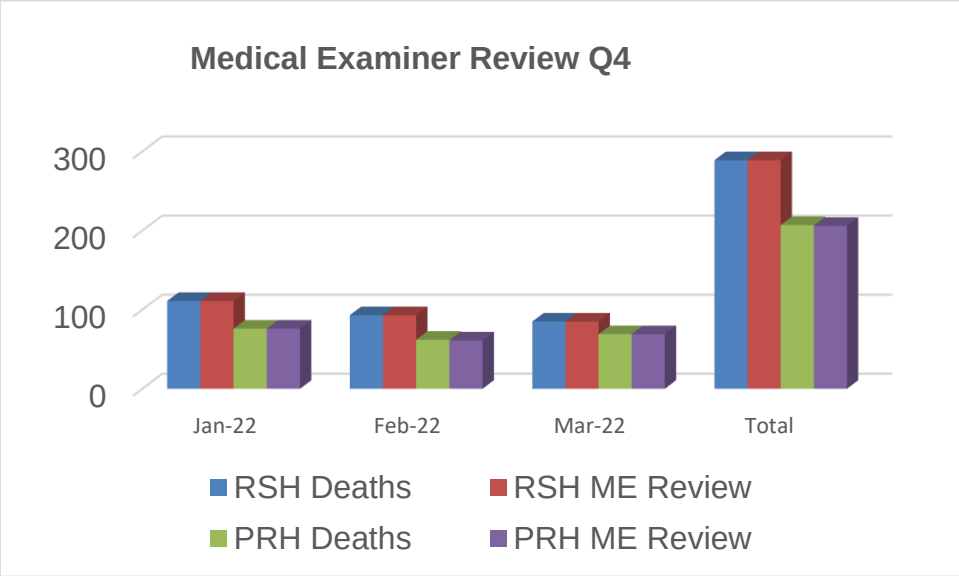




Medical Examiner Review.

Of the 496 deaths that occurred in quarter four, the Medical Examiner (ME) service reviewed 495 deaths, making referrals to the Coroner service, where appropriate and necessary, and liaised with and supported the families, taking the time to explain the cause of death or reason for coroner referral, and answering any questions the family members had regarding the care and treatment their relative received.

The one case that was not reviewed by the Medical Examiner was a direct referral to the coroner by the Police.



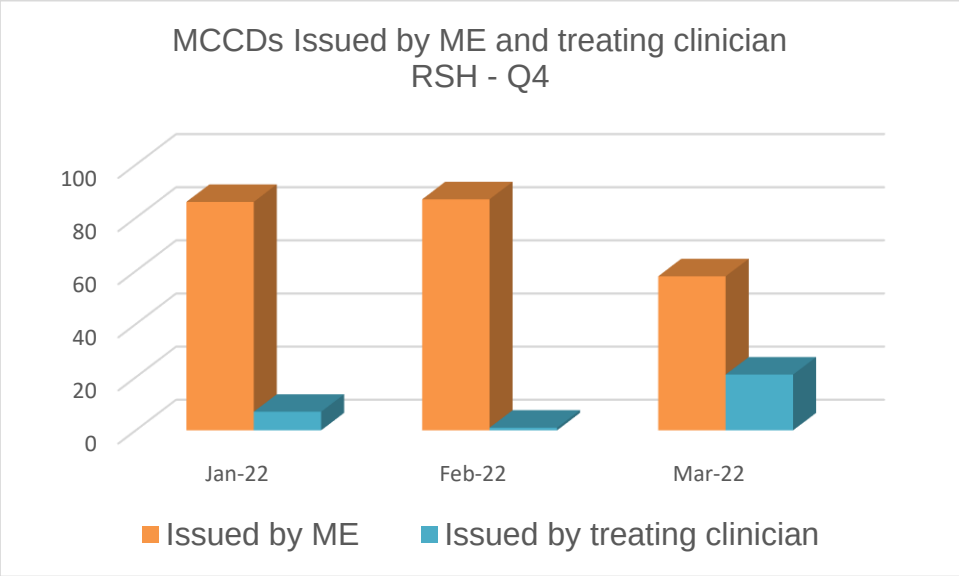
Medical Certificates of Cause of Death

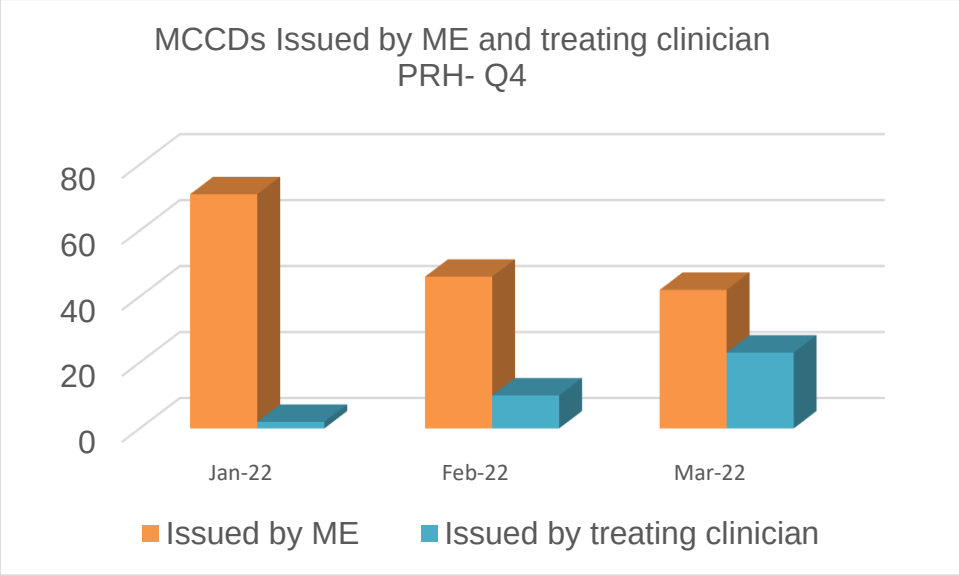
In quarter four the Medical Examiner service continued to work under the emergency Covid legislation which allows any medical healthcare professional to complete the MCCD providing they have spoken with a qualified attending physician (QAP) who had seen and treated the patient in the preceding 28 days. We have been working in this way since April 2020 to relieve the operational pressures of the clinical teams and so they can maintain their presence on the ward and with clinical duties.

However, anticipating the forthcoming Coronavirus Act easements, from the 24th March 2022, the ME service took the approach that where there was capacity for the treating

clinician to write the MCCD, they would be asked to do so, and so in quarter four there were some MCCDs written by the treating clinician.

In quarter four 454 certificates were written and issued by the Medical Examiner Service, with the cause of death being explained to all the bereaved families. This explanation takes place during the discussion the Medical Examiner has with the relatives once they have undertaken proportionate scrutiny and spoken with the treating clinician. This conversation can also be an opportunity for family to raise any questions they may have about the cause of death or raise concerns about the care their relative received or provide positive feedback.



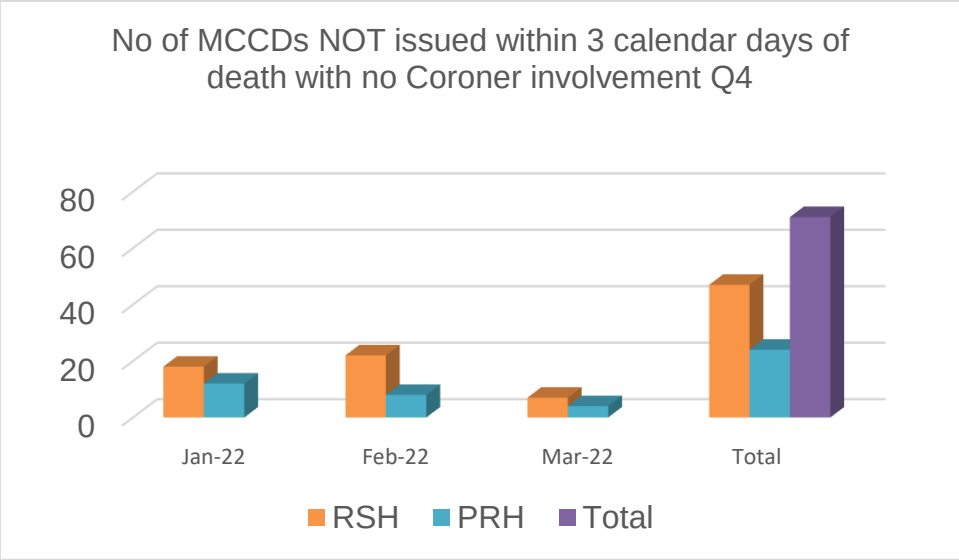


Of the 454 certificates written, 390 of them were completed by the ME with the remaining 64 MCCDs being written by the treating clinicians.

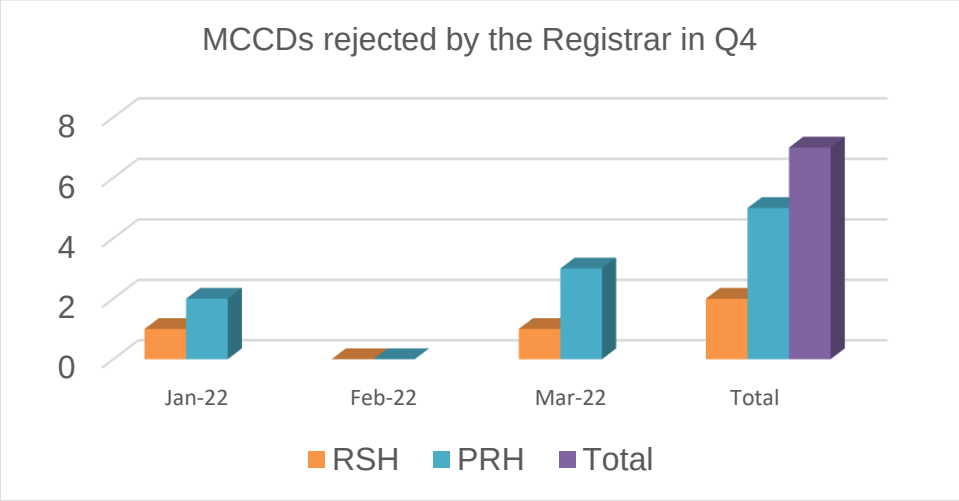
The Bereavement Service remains unable to invite bereaved relatives in to collect the Medical Certificate of Cause of Death (MCCD). The Registrar of Births Marriages and Deaths also remains off site with the main facility for registration of death being telephone registration. In partnership with Shropshire and Telford & Wrekin Registrar Services, the Bereavement Service processed the 454 MCCDs by sending these electronically to the Registrar Services so that telephone registration could be facilitated for the bereaved.

With the use of the Covid emergency legislation, it has enabled MCCDs to be written and released much sooner than in previous times, prior to the pandemic. Whilst our performance with ensuring the 5-day registration target has always been good, we are always assessing this and are mindful to ensure our work does not impact on this target.

The National Medical Examiner requires our service to submit quarterly data on the number of MCCDs not issued within 3 calendar days. You will see our performance in the graph below. Out of the 454 MCCDs issued, 71 of them were over 3 calendar days, which is a reduction on the previous quarter, however only by 5 and so this is an area of performance that is being monitored. However, this does demonstrate that by having the treating clinician complete the MCCD, is introduces more of a delay than when the ME was completing them. This has been fed back to the Regional ME.



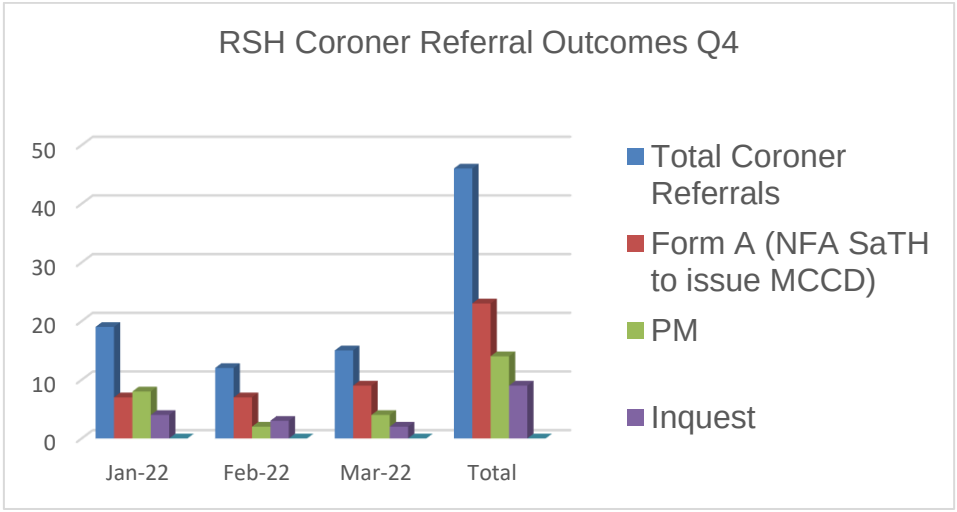
Although all adult deaths are reviewed by the Medical Examiner, and a sign off from this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD we have provided. In these cases the Registrar will either contact the Bereavement Service to discuss the cause of death, or they will refer the death directly to the Coroner. Out of 454 MCCDs issued, 7 were rejected in quarter three.

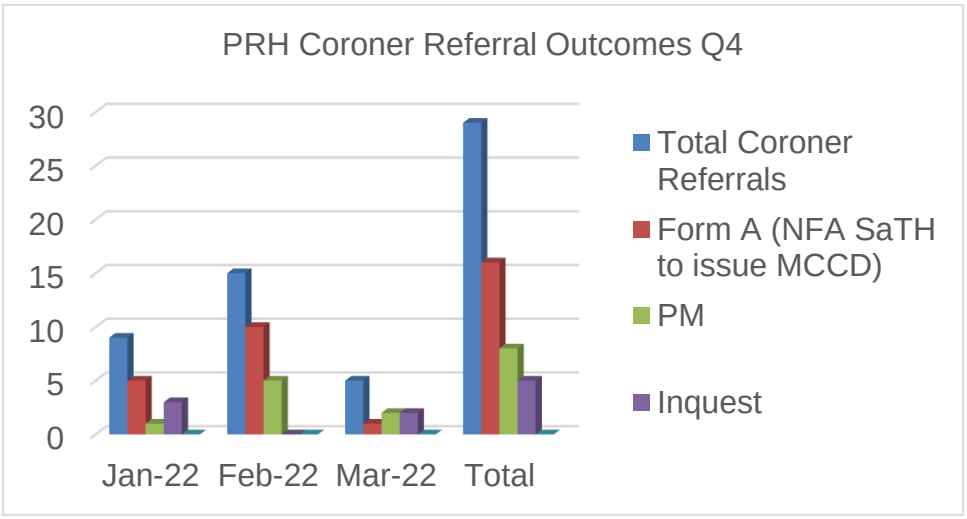


Coroner Referrals

All referrals to the Coroner are managed by the Medical Examiner Service and are made following ME review. In quarter four the service across both sites referred 75 deaths to the Coroner which is a reduction of 31 referrals from quarter three. The outcome of referring to the Coroner can vary between no further action being taken (Form A), to an inquest and

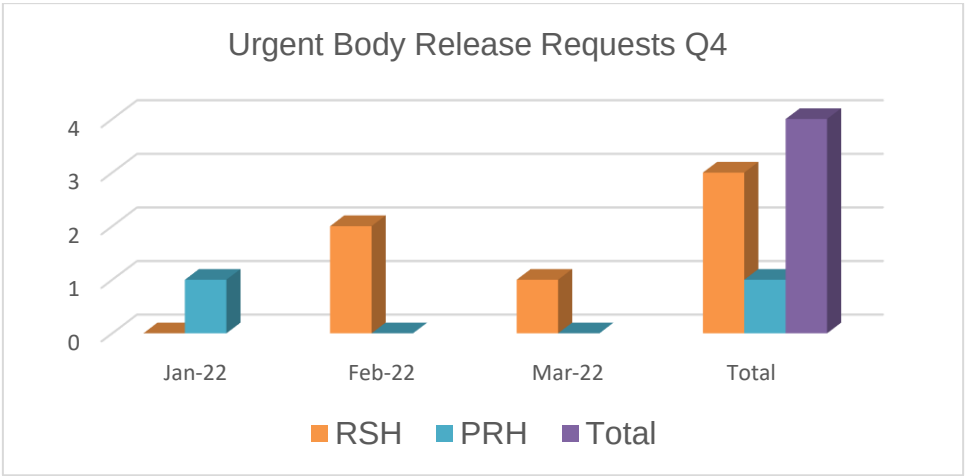
requesting a post mortem. A breakdown of the outcomes from these referrals for each hospital is below.





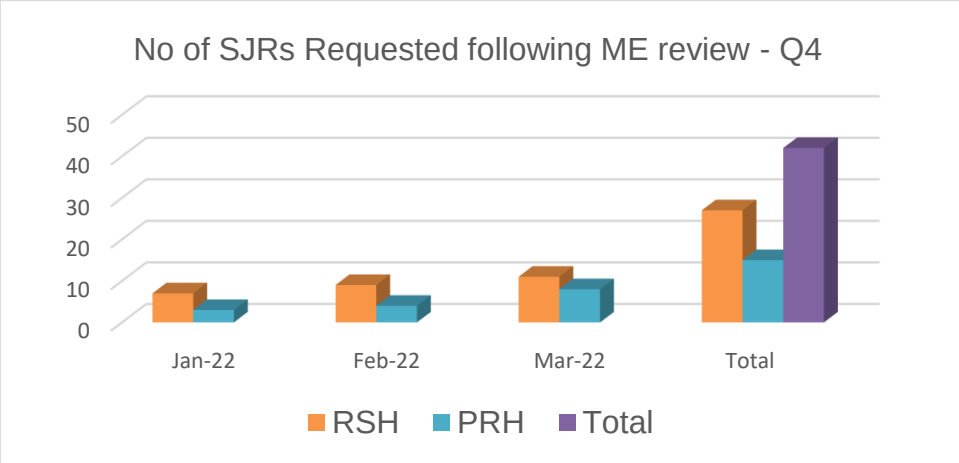
Of the 75 referrals made to the Coroner, he took no further action in 39 cases and took 36 for investigation by proceeding with a PM and or Inquest.

The National Medical Examiner wishes to know the number of cases we manage in respect of urgent body release. There were 4 requests for urgent body release during quarter four, of which all four requests were dealt with in the timeframe required by the families.

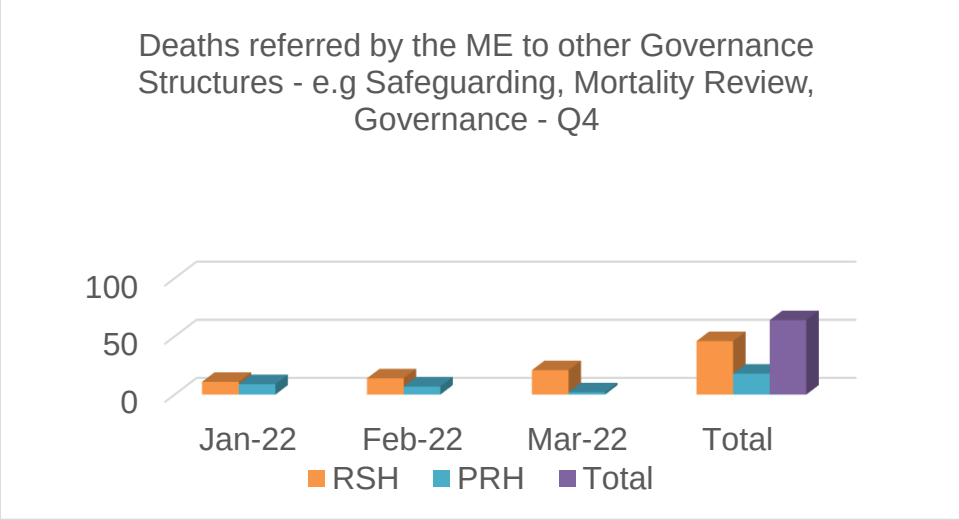


Part of the role of the medical examiner is to ensure any concerns or potential learning that has been identified as part of the review and discussion with the bereaved, is detected and then escalated. Work between the ME service and the Mortality Lead continues in how to ensure a robust process for escalating learning and potential SJRs takes place.

In quarter four the ME service requested 42 SJRs which was the same number as the previous quarter.



Completed ME reviews also identified potential learning in 64 cases, which were then referred on to the speciality for action and awareness. This data is also shared in the quarterly submission to the National Medical Examiner.



Medical Examiner and Bereavement Services Review

The ME and Bereavement Service continues supporting bereaved relatives, whilst not in person, but by maintaining contact with them over the phone and ensuring they know what action we are taking in respect of their relatives death. Families continue to receive our swan bereavement folders via the post to help provide ongoing support and we are still open to receive enquiries from bereaved relatives and provide ongoing support to them. Medical Examiners are continuing with their reviews of all deaths and an important part of this is the support they offer to the bereaved.

To support the intention of the National ME system rolling out the service to all non-coronial deaths, both in acute and non-acute settings, the ME Service in SaTH has held recruitment drives to attract more Medical Examiners to increase our capacity to take on the additional deaths. The need for additional MEOs is also there, and so recruitment for another MEO post also took place in quarter 4. It is anticipated that the National ME system will receive Royal Assent during quarter one of 2022/23 which paves the way for the system becoming statutory. A date for this is to be announced, but it is anticipated to become statutory by 1st April 2023. Therefore, SaTH will be the host site Medical Examiner Service for review of all deaths in Shropshire, Telford & Wrekin. The Bereavement & Medical Examiner Service

Manager will keen the board updated by sharing updates at the Trust's Learning from Deaths Committee.

Appendix 2

Examples of Feedback from Bereaved Relatives received in Q4
RSH

A&E

*"My wife only decided to go into hospital the day before she died so she was still in the casualty ward. The doctor phoned me at about 3.30 am on Sep 12. When I arrived I was met by a very sympathetic doctor who told me that he did not expect *** to live much longer. I was showed to *** who was in a quiet side room with gentle music playing. The two nurses who were with *** and me were brilliant and I was allowed to cradle ***. She died at 6.30 am, very peacefully, after one sedative was given by a Sister. I was allowed to stay with *** after she died and closed her eyes. Many thanks"*

A&E

*The family very much appreciated the care and sensitivity shown by all of the medical team: paramedics, nurses, doctors. *** (my dad) achieved his wish to spend his last days at home with the close family. On his last day he was in RSH for only a couple of hours. Re. Q13 we are aware that he was in pain on/off in his last days (and probably not telling us - at home). In those last couple of hours in RSH we understand that he was unconscious. He was treated respectfully and addressed by his name, "***", at our suggestion. We are very grateful to all of the medical professionals. Thank you.*

Ward 25

*"Observation 1: My wife, ***, had been given hours to live when she was moved into a side ward (for privacy). The doctor had stopped all medicines in agreement with me to let her pass quickly and so not to prolong suffering. After 5 hours of holding her hand and talking to her with no response whatsoever, 2 nurses came in and said they were going to rotate her. Bearing in mind she had been laying on her back every time I visited over the preceding 5 days, now they wanted to 'rotate' her. I asked for what reason and they said to prevent bed sores! I told them to leave her and don't be ridiculous. She had hours to live, was in no apparent discomfort, and was unconscious, so I made a decision for her. She died an hour later. I understand nurses have a duty of care but on this occasion, it was the wrong call.*

*Observation 2: An hour after my wife had passed, I made my way out to leave. It was 2 am. I asked the only nurse (a mature, *** lady) at the nursing station what do I do now and she said I should come back to the ward after 8 am and ask for the Administration Manager. I was back in Ward 25 at 8 am where I asked for the Admin Manager and got strange looks from 2 nurses. I explained about *** and one asked if I had the right ward. Of course I did. Whilst they went off to investigate, I asked a young *** lady (no uniform but a name badge and carrying files) if she was the Admin Manager.*

Cont….
She replied sharply, 'no, I'm the admin clerk…' and rushed off. The nurses came back and reached behind the nurses' station desk and passed me a bereavement bag and said this is what you want. The bereavement dept will be in touch in the next 24 hours. I said this is what I've just travelled 50 mile round trip for, in my emotional condition, to be given a bag of stuff I could have been given last night. The Sister apologised and tried to comfort me. In summary, my wife had had tremendous support from the NHS over 75 years and they have

kept her alive for far more than we expected given her complex problems, but what a sad testimony to finish on. Especially for a hospital that deals with patients dying every day of the week. I would say normally that more training is required but on these occasions I think bad decisions have been made and lack of knowledge about procedure is evident."

Ward 25

*"My mum was in A&E on admission and was looked after on the Pitstop area – the nursing staff were very pleasant whilst she was there. Frailty doctor and other doctor explained with kindness and empathy what the 'plan' was for my mum and I was in agreement with this. There were only two things which I felt sad about; the night staff Sister wasn't willing to give my mum morphine prior to her transfer to the side ward on 25G and I felt this was needed. She said 'I would have to wait 30 mins before moving her if given' – and I know they needed the bed space – so was mindful of this and didn't ask again. The ward staff 25G were very supportive, in particular Staff Nurse ***** who was kind and considerate throughout. The syringe driver wasn't obtained/available until several hours after agreed – it made a noticeable difference once inserted. But overall the care my mum received was excellent and I have no real concerns".*

HDU

*"I felt very happy (not the right word) but content that *** had been cared for wonderfully during his last week of life. The team on his last weekend kept us well informed and also allowed us to see him by giving us full PPE protection. We were allowed time before and after his death to be with him. Something many have been robbed of. So thank you from all the family".*

***A&E and* Ward 21**

*A&E & Respiratory Unit – Please pass my thanks to I believe *** and Dr ***** who explained to me fully how ill *** was. This really helped me to cope. I could say my goodbyes. The nurses on that ward had such kind words for patients. Ward 21 staff were very helpful on telephone but I did not have chance to meet them. They telephoned and *** had passed before I could get to hospital. Thanks to staff and Ward Sister.*

Examples of Feedback from Bereaved Relatives received in Q4

PRH

Ward 7

"Before we were able to visit the ward it is worrying to think what had been going on. My husband was in a nappy when I saw him, even though at this point he could use the toilet by having assistance – like the nappy was an easy option not to help him. This led to problems as he wouldn't go to toilet in the pad".

Ward 9

*"Upon *** admission on *** we did not realise how ill he had become; we knew he was very ill but we kept caring for him at home like we have done for the past few years. When *** was admitted to hospital we just thought another blip in his illness and we would return home together in a few days; this was not to be and came as a shock to the family, especially on Christmas day. *** had a fantastic life, loving family and would like to thank Princess Royal Telford for the tender loving care that everyone provided to *** and us as a family".*

Ward 8

"Thank you so much to all the PRH sta