The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
9 February 2023

Agenda item	020/23			
Report Title	How We Learn from Deaths Quarter 1 and 2 2022/2023 Report			
Executive Lead	John Jones - Executive Medical Director			
Report Authors	Dr Roger Slater, Fiona McAree, Lindsay Barker			
	Link to strategic goal:		**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:**	
	For noting	√		
			Link to risk register: ID435	
Presented to:	Trust Learning from Deaths Group 01 December 2022 QOC 20 December 2022 & QSAC 28 December 2022			
Executive summary:	• The care was rated as good or excellent in 65.5% of completed Structured Judgement Reviews during Q1 and Q2 2022/2023. • SJR completion rate has deteriorated during Q1 and Q2 2022/2023. Influences on this key metric are detailed in the report. • An improvement project with 7 workstreams is being developed in collaboration with the Trust Improvement Hub team to increase the rate of SJR completion. • There has been a deterioration in performance within the Medical Examiner Service relating to the issue of the Medical Certificate Cause of Death (MCCDs) within 3 calendar days of death since the withdrawal of the Coronavirus Act 2020. • One death within the Shrewsbury and Telford Hospital NHS Trust in Q1 and Q2 2022/2023 was determined to have been due to problems in healthcare and therefore potentially avoidable. • There is one open risk on the Trust Risk Register relating to recruitment within the Learning from Deaths team. • The Learning from Deaths Clinical Lead post remains vacant impacting the ability to progress the wider Learning from Deaths agenda and improve the SJR completion rate. • The NICHE Phase 2 Review recommendations are complete.			
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.

2.0 Summary of Hospital deaths

2.1 During Q1 and Q2 2022/2023, there were 1,022 deaths across both hospital sites within the Shrewsbury and Telford Hospital NHS Trust. Fig.1 provides a 12-month overview of deaths across the Trust from Q2 2021/2022 to Q2 2022/2023

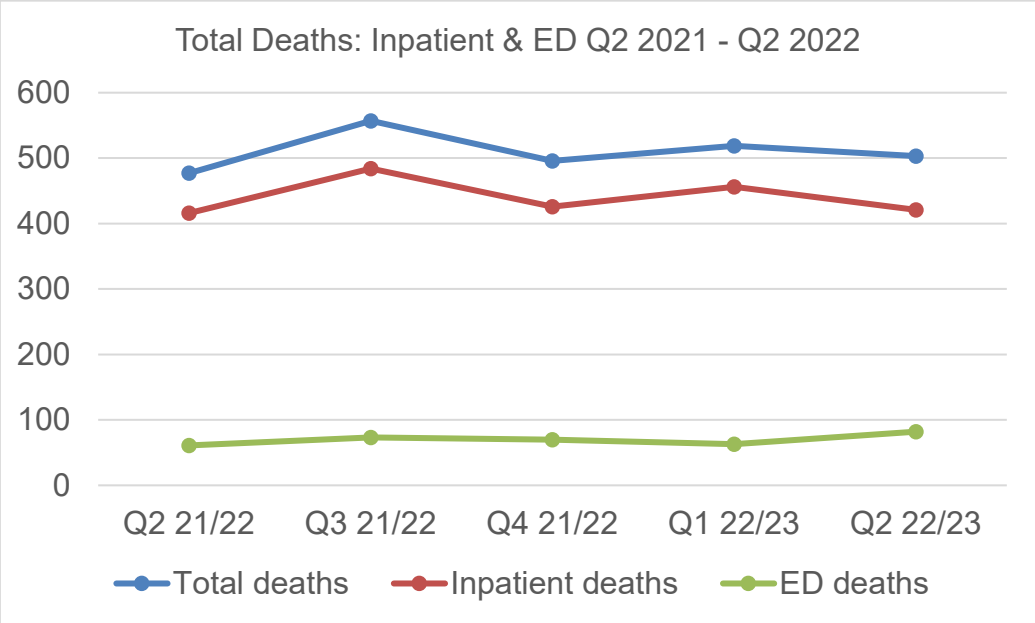


Fig.1

2.2 The total number of monthly deaths by site is shown at Fig.2.

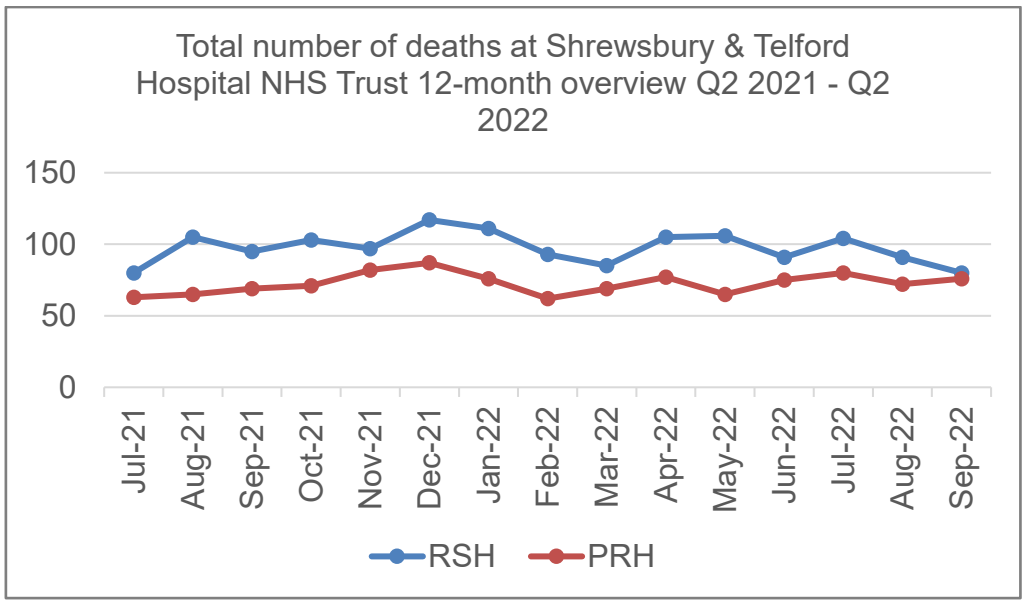


Fig.2

2.3 Fig. 3 provides an overview of inpatient deaths versus deaths in the emergency department across both hospital sites between Q2 2020/2021 and Q2 2022/2023.

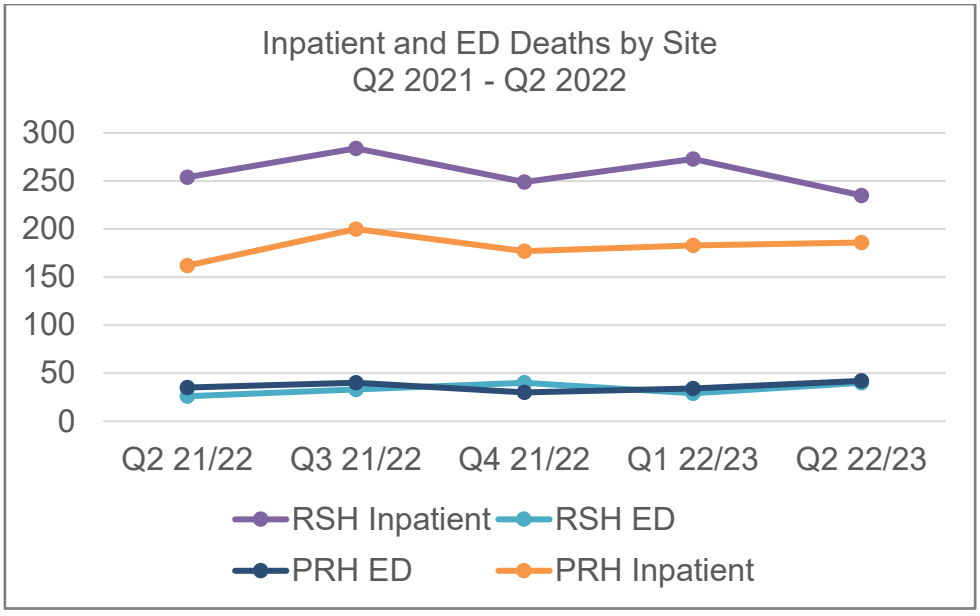


Fig. 3

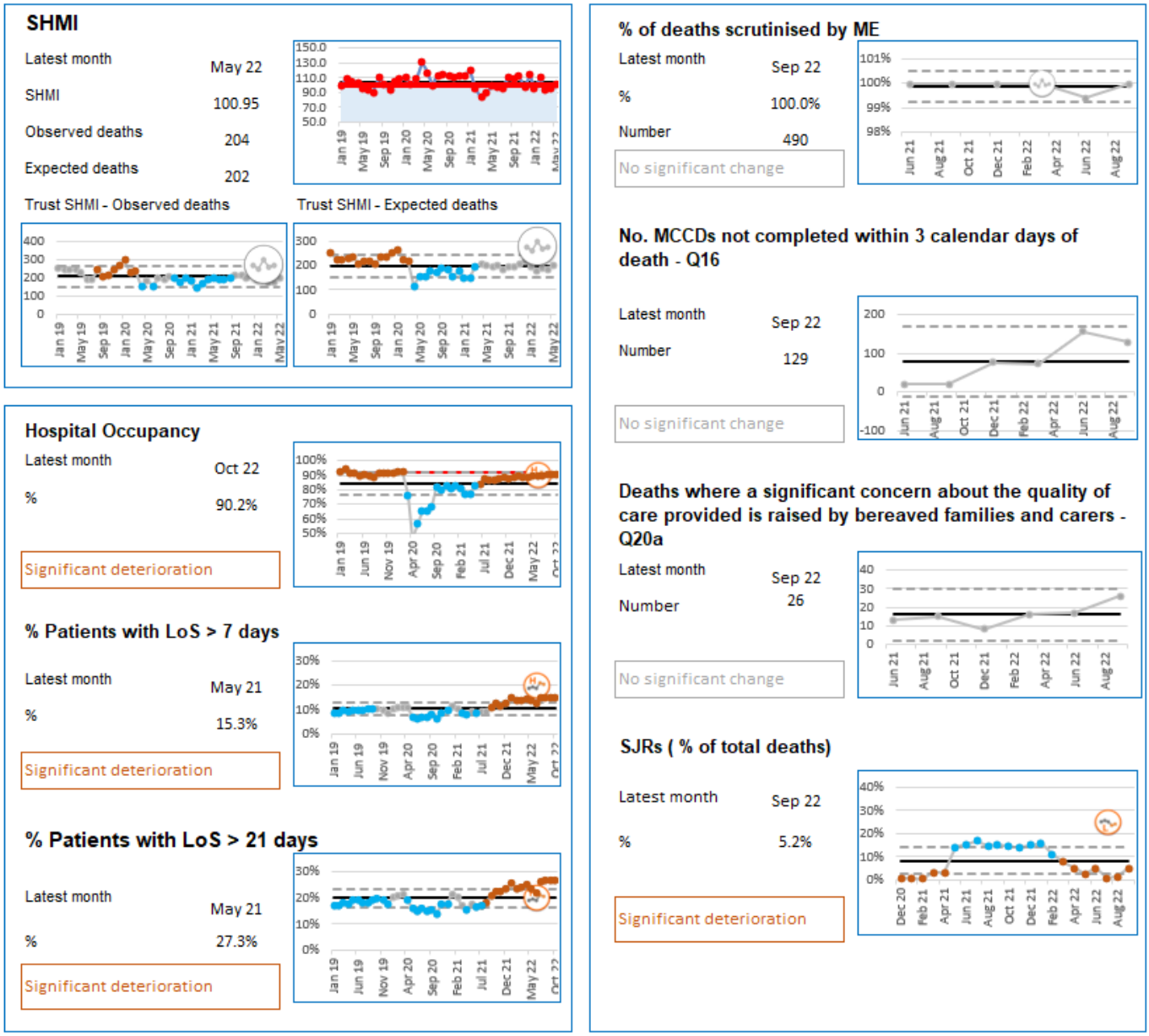
3.0 Learning from Deaths Dashboard

3.1 The Learning from Deaths Dashboard has been developed in collaboration with NHS England (NHSE). Key performance indicators have been incorporated to provide assurance to the Board and to provide context around the wider Learning from Deaths agenda within the Trust.

3.2 No Dr Foster Imperial alerts have been received during Q1 and Q2 2022/2023.

3.3 Overview of the Learning from Deaths Dashboard:

A overview of the dashboard is provided below highlighting key metrics relating to the context around learning from deaths and the from scrutiny to SJR.



3.4 SHMI – Summary Hospital-level Mortality Indicator

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

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 May 2022, is 100.95. The Trust SHMI position is favourable to the peer group identified within CHKS and is shown at Fig.4.

SHMI Trend Compared to Peer

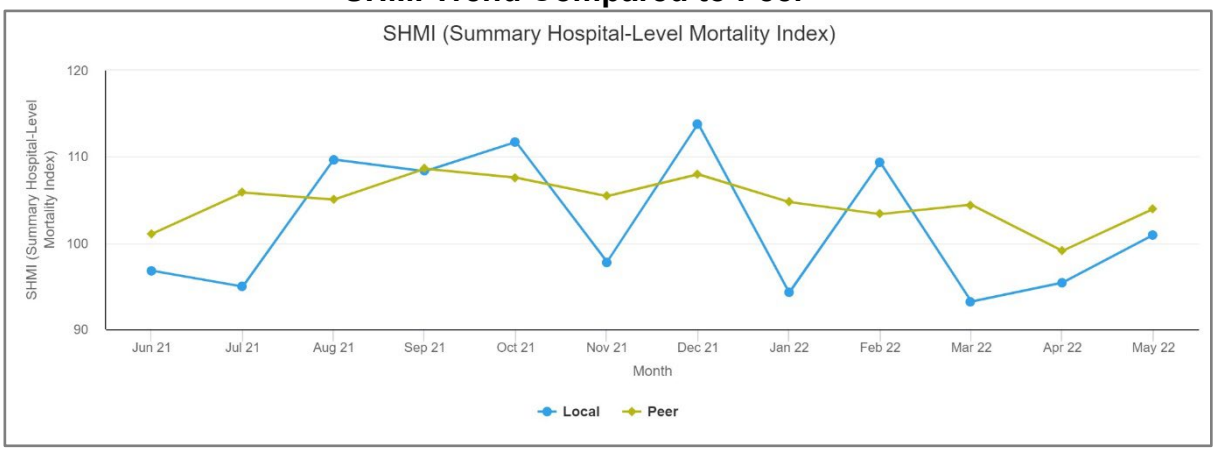


Fig.4 (Source CHKS)

Fluctuations in the Trust SHMI position from month to month can be expected and caution must be exercised when single month data is reviewed. A more reliable comparison to assess the Trust SHMI position versus the peer is to review the 12-month rolling trend. The Trust SHMI 12-month rolling trend position remains favourable to the peer group as is seen at Fig.5. When comparing hospital sites within the Trust, the SHMI 12-month rolling month trend SHMI is higher at PRH as per Fig.6. Work to review this difference between hospital sites is underway in collaboration with the CHKS representative in the first instance.

Rolling month trend compared to peer

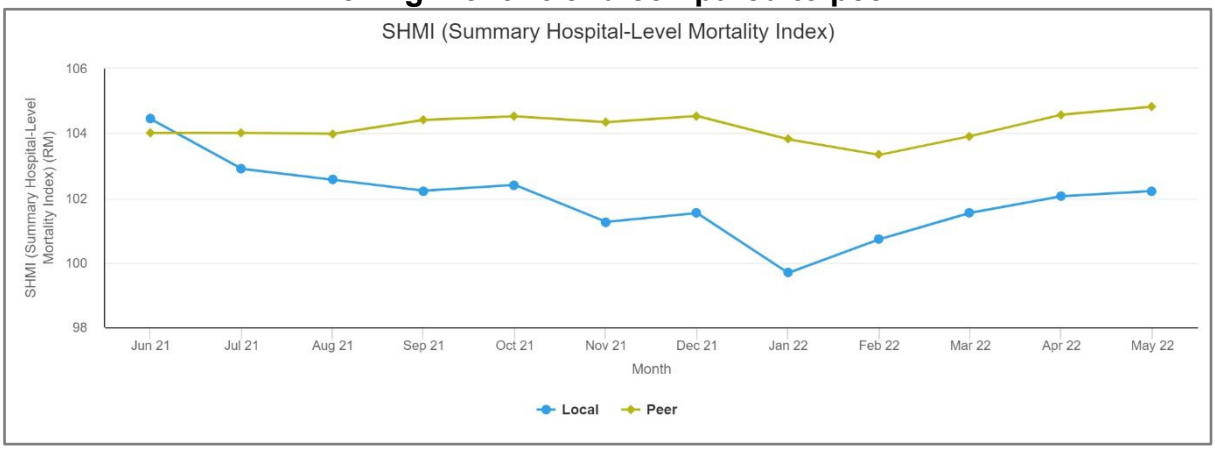


Fig.5 (Source CHKS)

SHMI Rolling Trend by Hospital Site

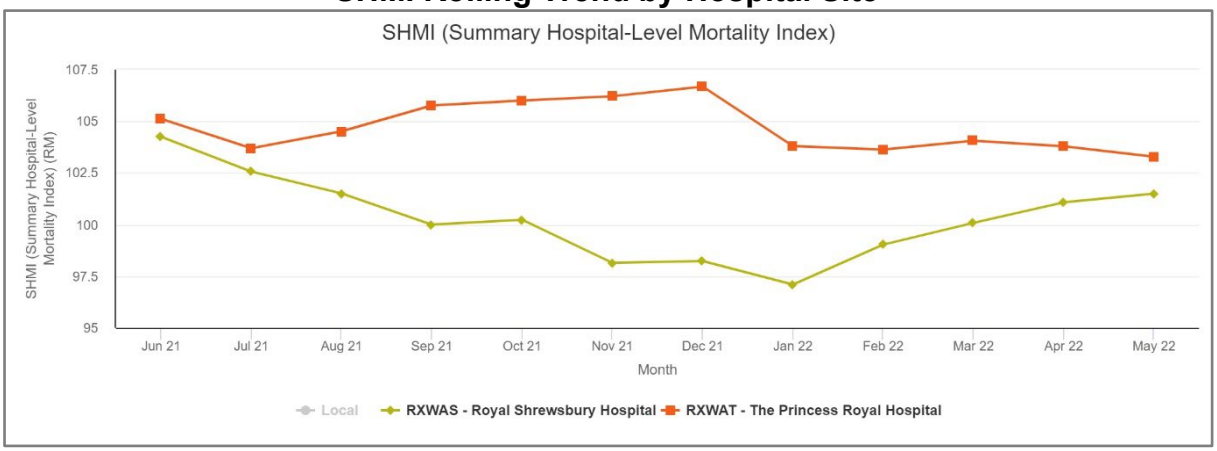


Fig.6 (Source CHKS)

3.5 SHMI Observed versus expected deaths

Comparing observed and expected deaths gives a greater understanding of any changes in the SHMI because it breaks down the two elements of the SHMI calculation – the numerator (observed deaths) and the denominator (expected deaths). A high SHMI value can be caused by a higher number of observed deaths, or a lower number of expected deaths. Expected deaths will be impacted by clinical coding.

The rolling trend for observed versus expected deaths is shown at Fig.7 and is monitored through the Learning from Deaths Dashboard.

Rolling month SHMI observed vs expected deaths trend:

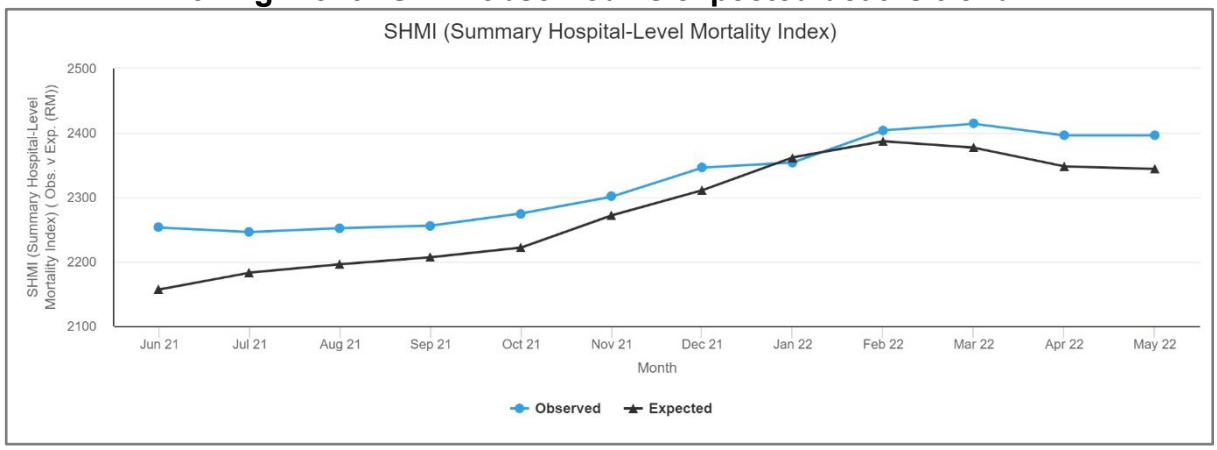


Fig.7

3.6 SHMI Details by Condition (Source CHKS)

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

- Acute and unspecified renal failure
- Urinary Tract Infection
- Anaemia

SHMI condition groups are assigned based on the primary diagnosis of the first episode of care.

3.7 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. This work is being further extended to review readmissions of patients with acute kidney injury (AKI) to identify if readmission contributed to increased mortality for this cohort.
The positive impact that the potential implementation of an AKI Intervention Team would have on the outcomes for this group of patients is being explored by the renal physicians, who have benchmarked this approach with other local Trusts in the region. The West Midlands AKI network is collating relevant achievements in this specialty and feedback will be reviewed when this becomes available.

3.8 Deaths where Urinary Tract Infection (UTI) was the primary diagnosis code:

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 7.

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

The number of patients identified within this cohort were small. A review of patients identified widespread comorbidities 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.

3.10 HSMR (Hospital Standardised Mortality Ratio) and RAMI (Risk Adjusted Mortality Indicator indicators)

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.

3.11 HSMR by condition:

The conditions with the highest number of 'excess' deaths (where there were more deaths than expected by the model) based on the primary diagnosis of the first episode of care are:

- Acute and unspecified renal failure
- Respiratory Failure; insufficiency; arrest (adult)
- Deficiency and other anaemia

3.12 RAMI – Risk Adjusted Mortality Indicator:

The RAMI indicator excludes Covid-19 patients.

3.13 RAMI by condition:

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

- Pneumonia
- Deficiency and other anaemia
- Respiratory failure; insufficiency; arrest (adult)

3.14 MCCDs not issued within 3 calendar days:

The National ME requires the service to submit quarterly data on the number of MCCDs not issued within 3 calendar days. From the beginning of April 2022, the Medical Examiners stopped writing MCCD’s due to the withdrawal of the Emergency

Coronavirus Act 2020. Responsibility for this now sits with the treating clinician. Performance in this key metric has subsequently deteriorated significantly during Q1 and Q2 2022/2023. The significant pressure treating clinicians are under clinically results in delays in being released from the clinical area to attend the bereavement office to complete the MCCD. Out of the 892 MCCDs issued in Q1 and Q2, 285 of them were over 3 calendar days. The bereavement team support the doctors to facilitate as timely completion as possible and ensure registration services remain appraised of the situation.

The increase in the number of MCCDs being issued over 3 days since the withdrawal of the emergency legislation is shown at Fig.8.

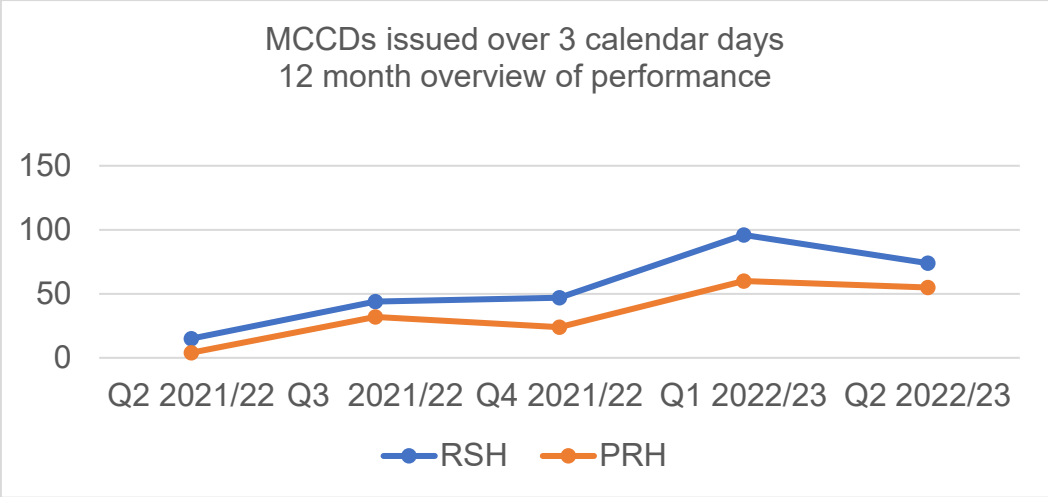


Fig.8

3.15 Deaths where a significant concern about the quality of care is raised with the Medical Examiner by bereaved families and carers:

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.

In Q1and Q2 2022/2023, 43 cases were referred by the Medical Examiner for an SJR based on significant concerns raised by the bereaved. The number of significant concerns raised by bereaved families has increased significantly to the previous quarters.

Two of these cases are being investigated as serious incidents and 6 cases are progressing through the formal complaints process at the time of this report.

3.16 Completion of Structured Judgement Reviews (SJRs):

To date, 31 SJRs have been completed for deaths in Q1 and 2, providing a current SJR completion rate of 3.03% of all deaths within Q1 and Q2. The latest single month completion rate for September is 5.2%. Whilst the September rate is encouraging, the overall percentage falls below the NHSE recommended target of 15-20% and significantly lower than the 13.1% now achieved to date for Q4 2021/2022 deaths. It is however important to consider the overall number of reviews completed where

learning is identified for all deaths not just SJRs and ensure that the number of cases flagged for SJR is appropriate to increase SJR completion rates.

The reason for the deterioration in SJR completion is believed to be multi-faceted:

- Resource challenges within the divisions to undertake SJRs due to current clinical workload and insufficient SJR reviewers.
- The vacant corporate Clinical Lead for Learning from Deaths post required to support the divisions with SJR completion, especially relating to training requirements and quality assurance.
- The revised learning from deaths process which commenced January 31st, 2022, removed the routine completion of SJRs for all deaths in the Emergency Department, and introduced a targeted approach through ME Scrutiny and mortality screening as recommended by NHSE. This resulted in an inevitable and expected decrease in the number of SJRs being completed. The aim is to increase the number of cases being appropriately flagged for SJR – this will be improved when random sampling is introduced, when the pool of available SJR reviewers increases.

3.17 The Learning from Deaths team are working collaboratively with the Trust Improvement Hub team to develop a programme of work over the next 12 months to improve SJR completion rate compliancy. 7 workstreams have been identified, each of which will require a nominated workstream lead and the involvement of key stakeholders. The workstreams have been identified as:

- Workstream 1: Resources, roles and responsibilities.
- Workstream 2: Data management (Divisional and Corporate).
- Workstream 3: Education and Training, to include quality assurance measures.
- Workstream 4: Culture, Communications and Public Relations.
- Workstream 5: Triangulation and Learning, to include Learning from Deaths representation at appropriate Divisional / Trust forums.
- Workstream 6: Notes management
- Workstream 7: Learning from Deaths integration with PSIRF.

4.0 Deaths in patients with Covid-19

4.1 Q1 mortality data for patients who died with a positive PCR result for Covid-19 and whose deaths were reported to NHS England is charted at Fig.9 below for each hospital site. During Q1 83 Covid-19 related deaths were reported which represents an increase of 7 cases from the previous quarter, and a significant increase from the same quarter of 2021/2022, when only 2 Covid-19 related deaths were reported.

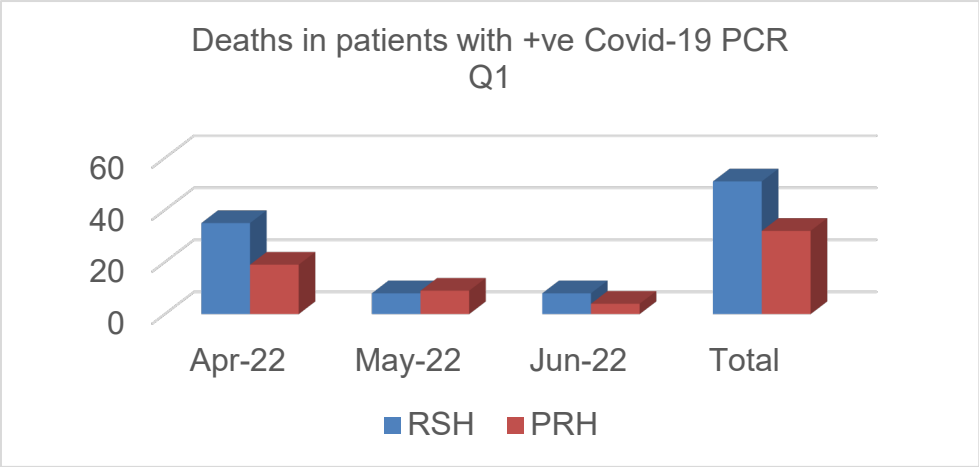


Fig.9

4.2 During Q2 2022/2023, 82 Covid-19 related deaths were reported, which represents a decrease of 1 case from Q1 – see Fig.10. However, this was an increase of 42 cases from the Q2 2021/2022 of the previous year, when 40 Covid-19 related deaths were reported.

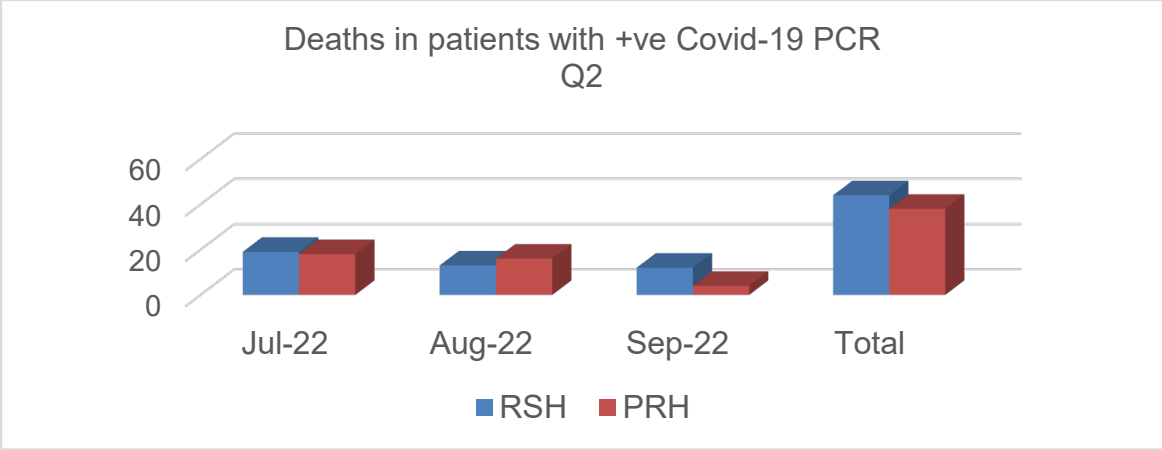


Fig.10

4.3 The chart at Fig.11 provides an overview from Q2 of 2021/22 to Q2 2022/2023 where a steady increase of patients who tested positive for covid 19 in the 28 days prior to their death can be noted.

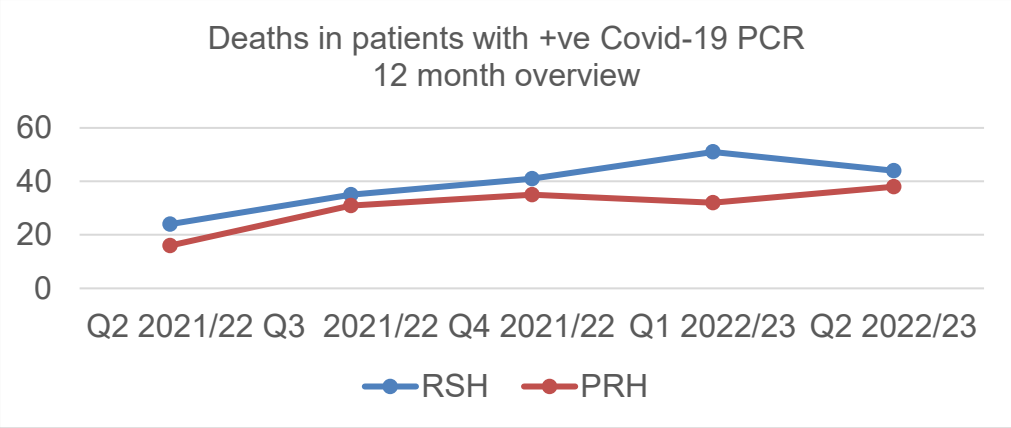


Fig.11

5.0 Medical Examiner Scrutiny to SJR

5.1 Of the 1,022 deaths that occurred in Q1 and Q2, the Medical Examiner (ME) service independently scrutinised 1,020 deaths (99%), making referrals to the coroner service, where appropriate and necessary. The ME Service team liaise with and support families, explaining the cause of death or reason for coroner referral, and answering any questions the family members have regarding the care and treatment their relative received. The two deaths that were not reviewed by the ME were direct police referrals to the coroner in Q1.

5.2 Medical Certificates of Cause of Death (MCCD):

The Emergency Coronavirus Act was withdrawn in April 2022 resulting in the responsibility for MCCD completion returning to the treating clinicians rather than the Medical Examiners.
In Q1 2022/2023, 459 certificates were written and issued by the ME and Bereavement Service (Fig. 12). This includes the MCCDs that the coroner has requested are issued with a Form A provided as these cases have not proceeded to investigation. The ME explains the cause of death to 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.

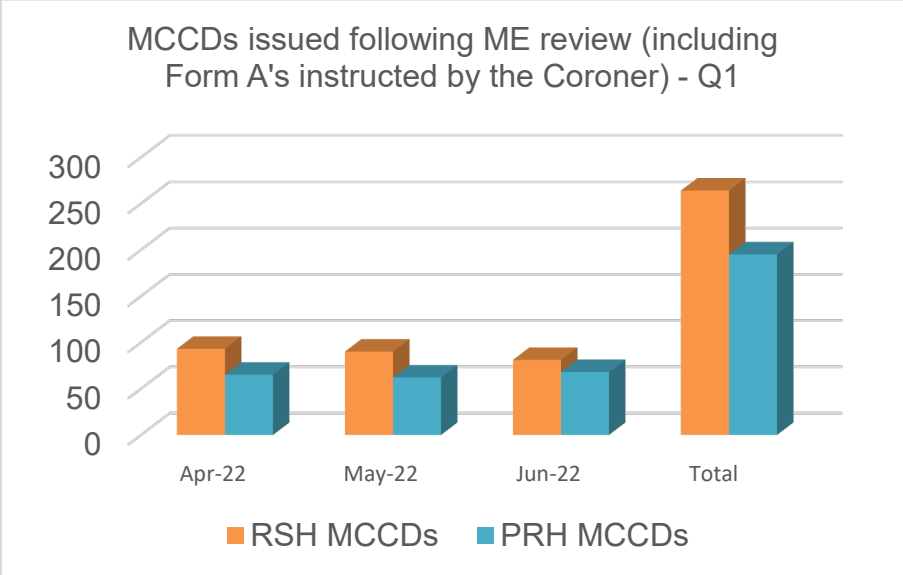


Fig.12

In Q2, 433 certificates were written and issued by the ME and Bereavement Service (Fig.13).

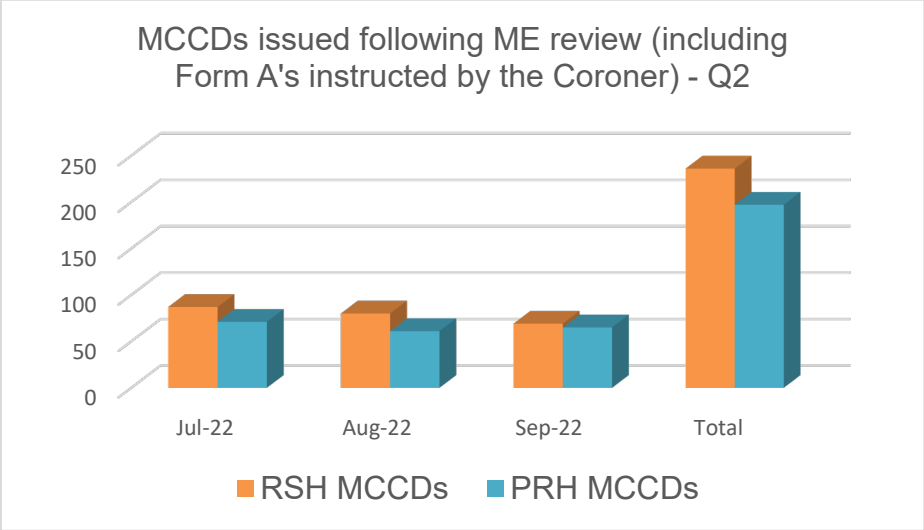


Fig.13

The Bereavement Service team do not now invite bereaved relatives into the hospital to collect the MCCD as the transfer of certificates electronically to registration services has been established.

5.3 Rejection of MCCD by the Registrar:

Out of 459 MCCDs issued in Q1, 2 were rejected. There were no MCCD rejections in Q2.

5.4 Urgent body release/faith requests:

The Medical Examiner Service report the number of cases where there has been an urgent body release for faith purposes. There were 4 requests for urgent body release during Q1 2022/2023, all managed in the timeframe required by the families. There were no urgent body requests received in Q2 2022/2023.

5.5 Coroner Referrals:

Referrals to the coroner are managed by the Medical Examiner Service and are made following ME review. In Q1 and Q2 2022/2023 the service across both sites referred 205 deaths to the coroner. The outcome of the referral may vary between no further action being taken (Form A), a post-mortem, or an inquest. A breakdown of the outcomes from these referrals for each hospital is shown at Fig.14 and Fig.15, broken down by Q1 and Q2.

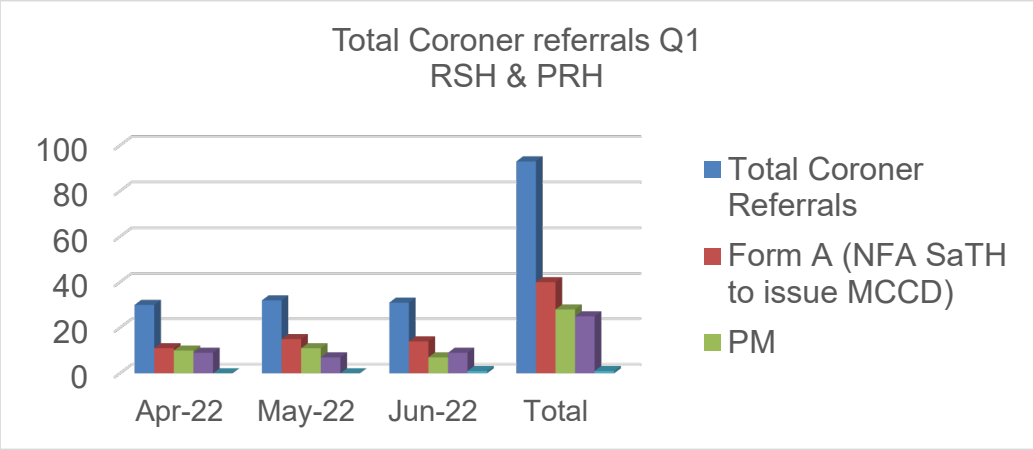


Fig.14

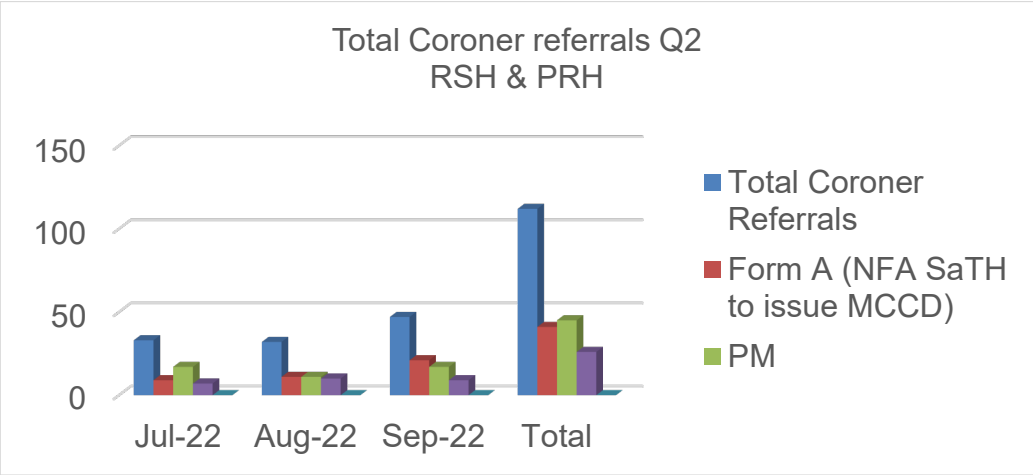


Fig.15

In the 12-month period to the end of Q2 2022/23 there have been 562 referrals to the coroner (Fig.16).

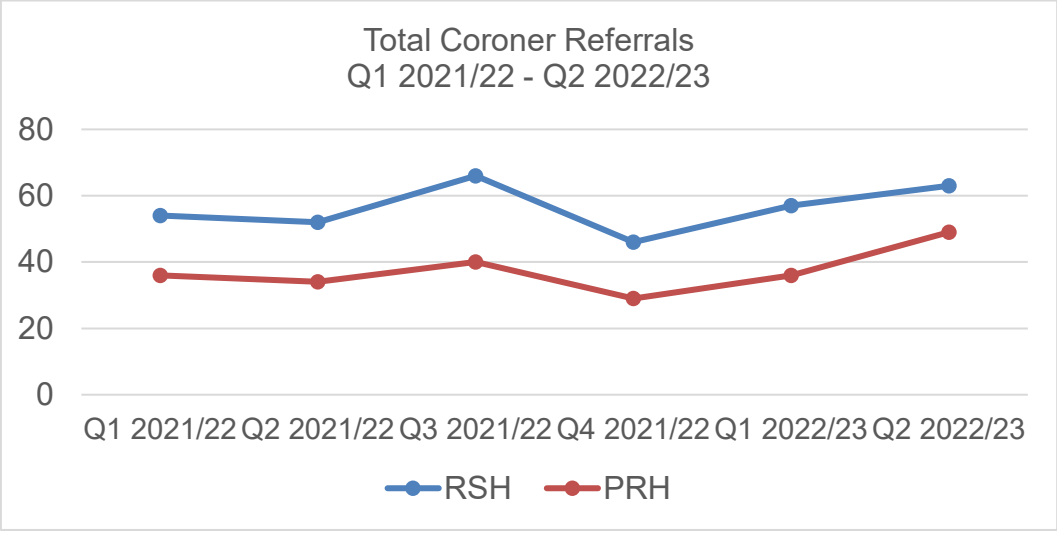


Fig.16

5.6 Referral for SJR:

Of the 1,022 deaths between Q1 and Q2 2022/2023, the ME identified potential learning in 164 cases and recommended an SJR in 89 cases. Cases where the ME identifies potential learning and/ or an SJR are discussed at the weekly Trust Mortality Triangulation Group (MTG) to ensure that these are referred appropriately for further

action at divisional level. This also aims to ensure that the cases are being managed through the most appropriate governance process to address the concerns raised, avoid duplication of review and also ensure that the expectations of the bereaved are being met. Cases where a serious incident has already been reported or where a divisional investigation is being undertaken, will not progress to SJR. On occasions, the ME identifies cases for SJR where the concern has been about care provided by another service, for example primary care or West Midlands Ambulance Service (WMAS). These are referred accordingly and will not progress to an SJR within the Trust. Cases where a concern about the management of sepsis is identified are referred to the sepsis team for 'sepsis validation'. The sepsis team review the care and identify both positive and negative learning which is shared with the divisions. On completion of sepsis validation, a datix will be completed by the sepsis team when a patient safety incident relating to sepsis management is identified, the case may be referred for SJR or the case may be closed when no significant learning is identified following sepsis validation.

5.7 Mortality screening using the online screening tool available within the Trust remains widely utilised across the divisions to flag cases for SJR when the ME has not already flagged a concern. Screening is also used to flag positive examples of care or refer cases for sepsis validation.

5.8 67 of the 89 cases flagged by the ME for SJR during Q1 and Q2 2022/2023, have been allocated to the divisions for SJR completion. Fig.17 provides a summary of the reason why the SJR did not progress in the remaining cases.

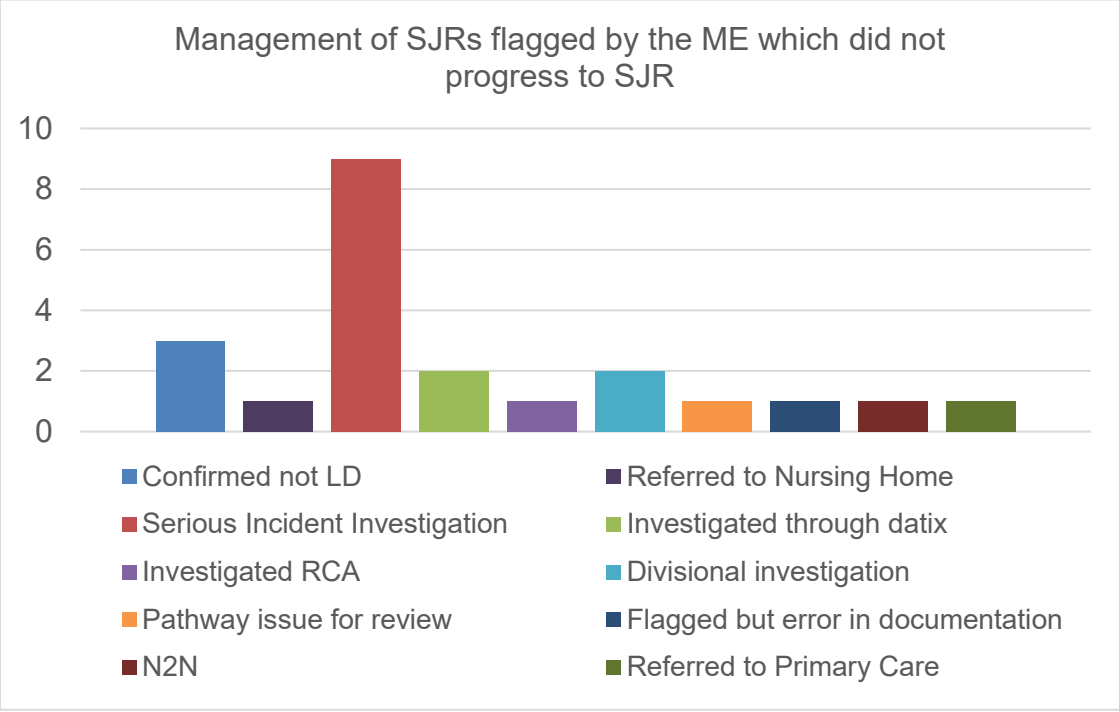


Fig.17

5.9 In Q1 and Q2 2022/2023, 469 online mortality screenings were received for the 1022 deaths that occurred in the period within the Trust. For clarity, 100% of all deaths are independently scrutinised by the ME and for Q1 and Q2 an additional level of clinical scrutiny was provided by mortality screening. Mortality screening is available for deaths where the ME has not already flagged an SJR to be completed and may be completed by different clinicians within the multi-disciplinary team.16 additional SJRs were identified through this process bringing the total SJRs flagged for deaths in Q1 and Q2 to 84, or 8.22% of all deaths.

6.0 Care ratings for patients who have died in Q1 and Q2 2022/2023 and where an SJR has been completed

6.1 Fig.18 below provides a summary of the care ratings awarded in the 29 mortality reviews completed during Q1 and 2 2022/23 for care provided within the Trust using the online SJRPlus. Ratings are provided according to:

- The first 24 hours care
- Ongoing care
- End of life care

Fig.19 shows the ratings for RSH and Fig.20 for PRH

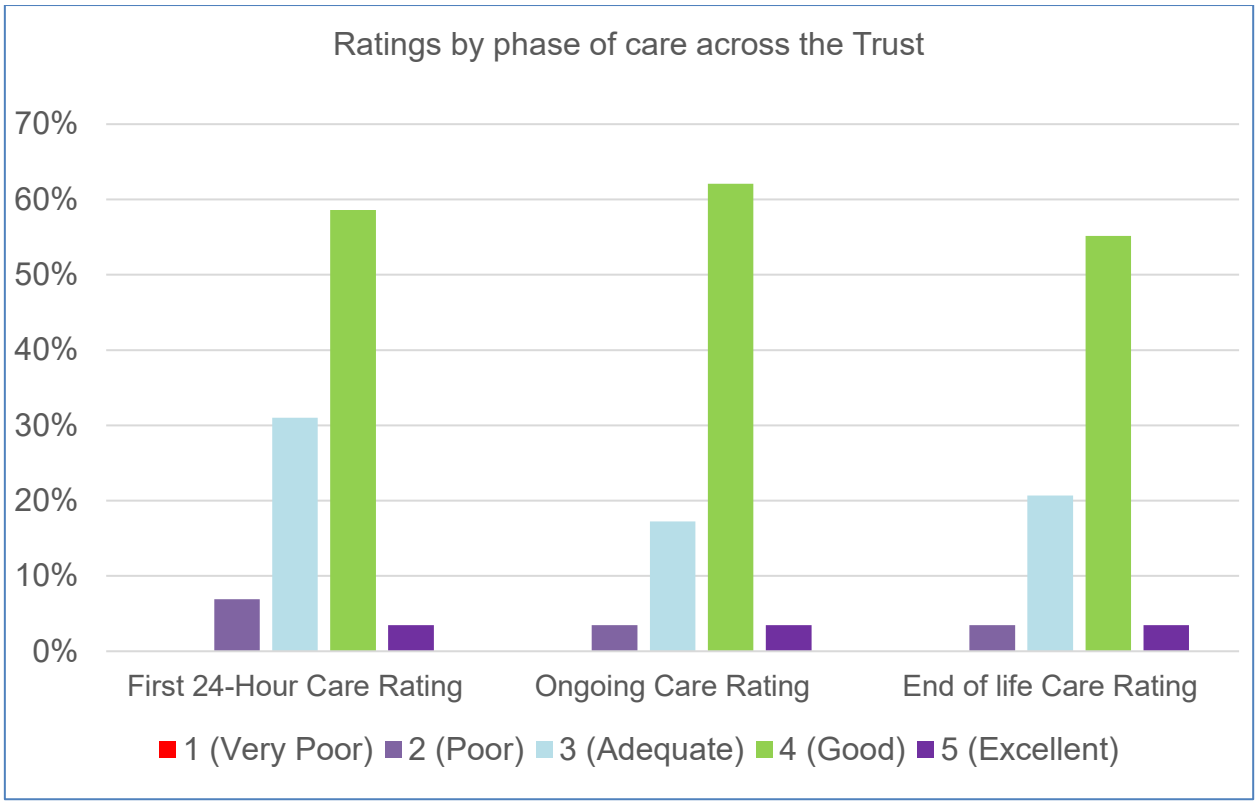


Fig.18

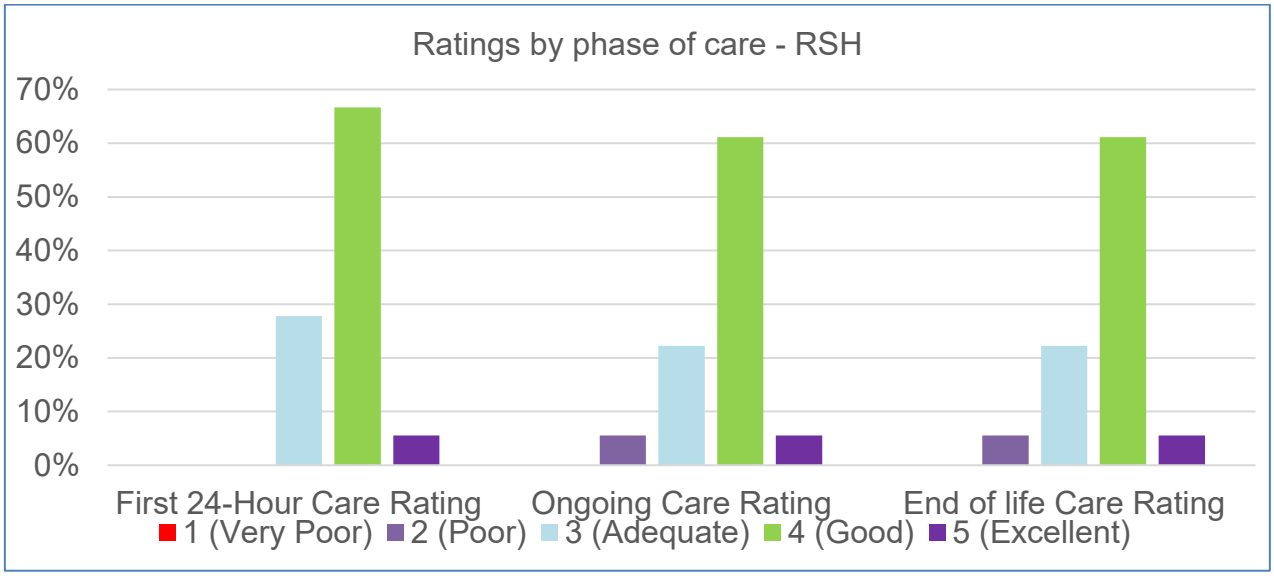


Fig.19

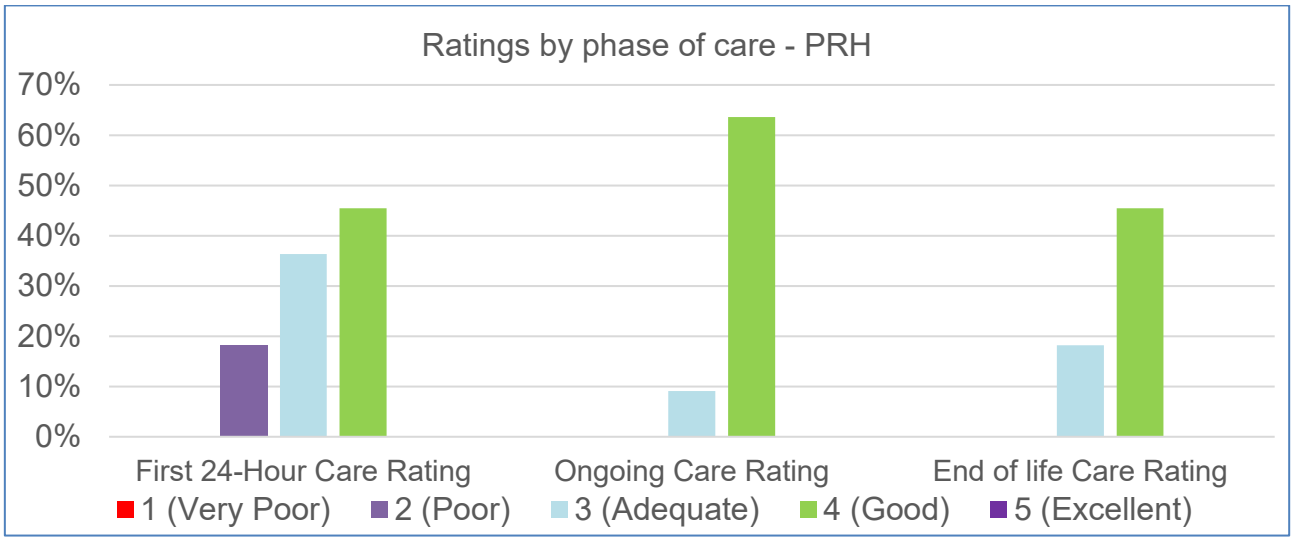


Fig.20

6.2 The overall assessment of care ratings across the Trust are provided at Fig.21 with a further breakdown of ratings for RSH at Fig.22 and PRH at Fig.23

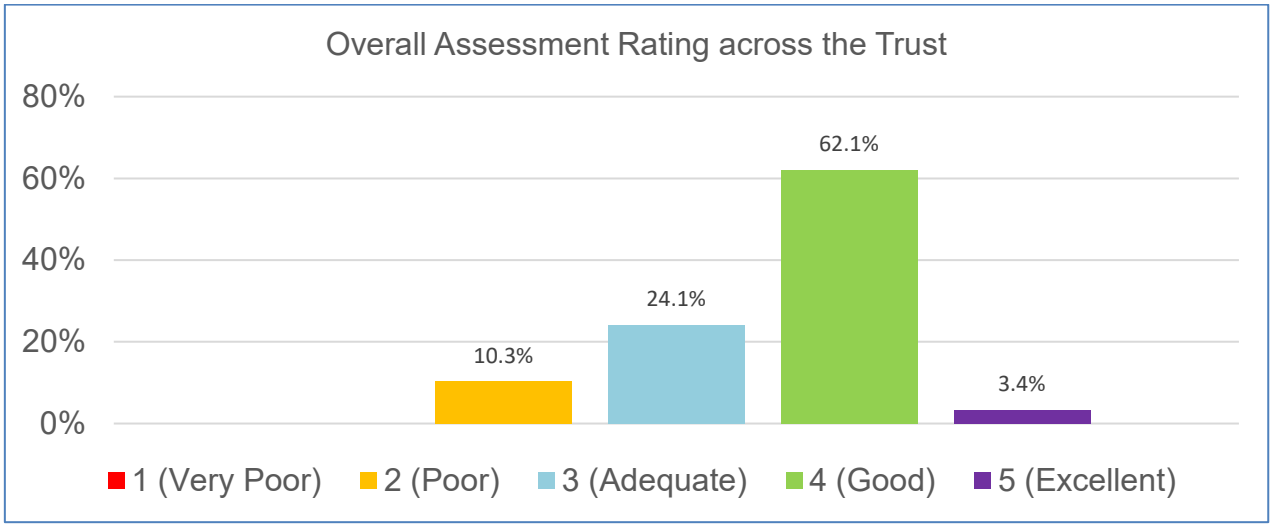


Fig.21

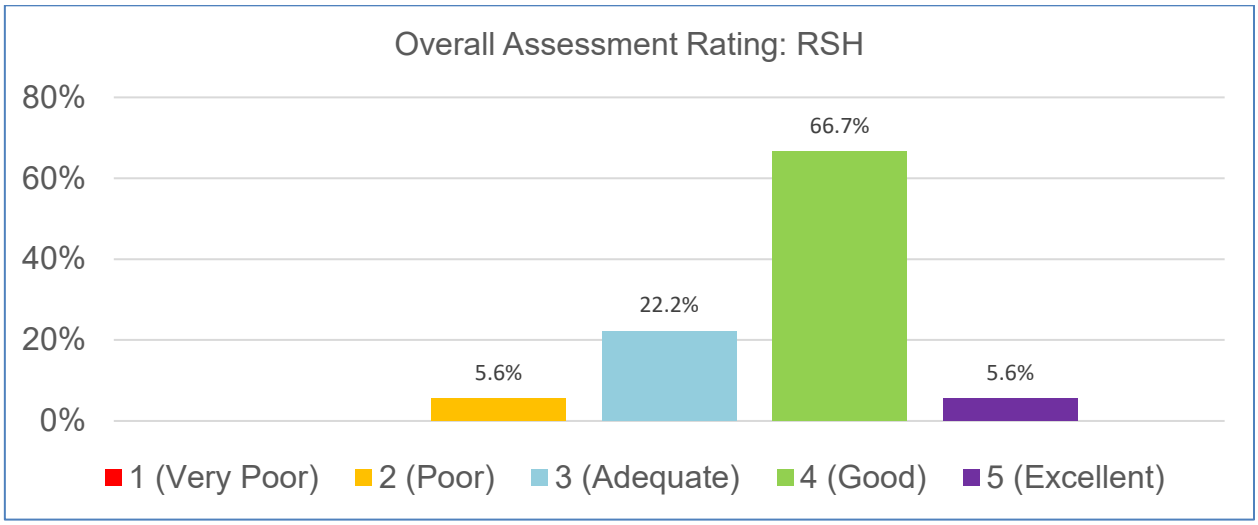


Fig.22

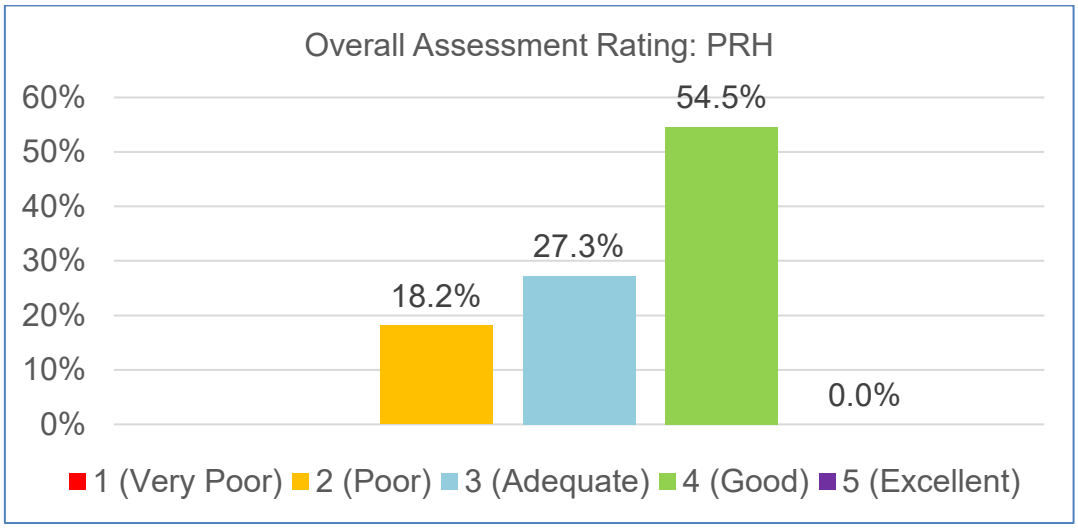


Fig.23

6.3 Examples of good / excellent care and positive learning identified within the 29 completed SJRs:

- Good teamwork on ward to ensure that patient wishes were heard, respected and followed in an appropriate and timely way.
- Excellent nursing documentation under pressure.
- Excellent written and verbal communication with the patient and family, enabling a safe transition to home which was the preferred place of care.
- Good evidence of Duty of Candour.
- Rapid recognition, management and escalation of a deteriorating patient.
- Regular senior clinical input to care.
- Good frailty reviews.

Specific positive themes noted within the 29 SJRs:

- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms being used, specifically evidence of good quality discussions / communication with patient and family.
- Good end-of-life care including use of anticipatory medicines and the provision of holistic care.
- Good documentation.
- Early involvement and reviews by specialities including ITU, Specialist Nurses and Learning Disability team.

6.4 Four cases out of the 29 completed SJRs during Q1 and Q2 2022/23 were identified as having a care rating of poor or very poor either in one of the phases of care or overall. 3 of these cases involved a significant ambulance offload delay. None of these cases have been reported externally as serious incidents.

Key learning identified:

- **Case 1:** A significant ambulance offload delay was experienced by this patient. The reviewer highlighted a lack of continuity of care, the need to improve liaison between clinical teams and the lack of clinical 'ownership' for the patient with no single Consultant prepared to take responsibility for making treatment and escalation decisions. Documentation relating to the clinical rationale when the patient was transferred between sites required improvement. The patient's family were not informed of the transfer to RSH and subsequently turned up

to visit at the wrong site. A ReSPECT form was completed 2 hours before the patient died and the reviewer felt there were missed opportunities to complete this earlier and communicate the patient's deterioration to the family. Fluid balance charts were variable in accuracy. There was some positive learning identified in this case relating to good clinical assessments being provided by the medical junior doctor, and medical registrar.

- **Case 2:** A significant ambulance offload delay was experienced by this patient and a subsequent delay in receiving an appropriate clinical assessment in the Emergency Department. A delay of over 4 hours in a Tropinon blood test arriving at the laboratory was identified.
- **Case 3:** The reviewer identified diagnostic investigations (CT abdomen and CT pulmonary angiogram)) inappropriately booked for the patient who was significantly deteriorating – the patient was taken for a CT but needed to be transferred to the resuscitation department in the Emergency Department for intubation and attempted stabilisation. Poor documentation relating to timings of consultant review was identified in the notes as well as the lack of a medical consultant to ITU consultant discussion, which the reviewer believed would have been appropriate. The reviewer also identified positive learning for this case – prompt recognition and escalation of deterioration by nursing staff, with appropriate response from the medical registrar.
- **Case 4:** A significant ambulance offload delay was experienced by this patient, leading to a delay in review and administration of intravenous antibiotics and diagnostics for potential sepsis. However, once the patient had been assessed, the reviewer identified that all appropriate care was provided including sepsis assessment and nursing risk assessments.

6.5 Other negative learning identified within the 29 completed SJRs includes:

- The need to ensure a discharge letter is printed and filed in the notes to allow clinicians who do not have access to the portal to review discharge plans.
- Recognition of the dying patient needs to be improved.
- Lack of MCA, Best Interest and DoLs documentation.
- Delays in the administration of anticipatory medication towards end-of-life.
- Lack of support for junior medical staff.
- Poor use of food charts.
- Earlier referral to speech and language team (SALT) required.
- The need for out of hours echocardiography.
- Failure to recognise how unwell a patient was in the early hours of the morning.
- Lack of consultant involvement in diagnosis and complex decision making.

6.6 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.

6.7 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, remains 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. Routine divisional reporting of learning from SJRs, complaints and serious incidents including thematic analysis pertaining to patients who have died, has been

commenced and is now a standard agenda item at the Trust Learning from Deaths group. This reporting will continue to develop over the coming months.

6.8 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. Members of the Learning from Deaths team will attend the Trust PSIRF Steering Group to ensure the agenda is appropriately represented as planning and implementation progresses.

6.9 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 14 of this paper will assist this when the relevant posts have been filled and are established in role.

7.0 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.

7.1 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.

7.2 End-of life care improvement work

The Learning from Deaths team continue to refine integrated working practises with the End-of-Life and Palliative Care Lead Consultant to share learning identified through the Learning from Deaths agenda especially where concerns are raised by the Medical Examiner Service. The information is now being themed and shared with the STW Integrated Care System End-of-Life and Palliative Care Steering Group to inform wider learning. Current themes relate to:

- Fast track discharge problems.
- Poor compliance with the utilisation of an individualised plan of care for patients expected to die.
- Appropriate and timely use of ReSPECT forms including recognition and review of existing ReSPECT forms when patients are admitted to hospital.

Improvement work related to end-of-life care is integrated into the relevant Getting to Good programme of work and facilitated by the End-of-Life and Palliative Care teams. 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. This work is being driven collaboratively with the Trust Improvement Hub team, incorporating End-of-Life, Therapies, and Complex Discharge teams, with a focus on:

- Processes.
- Education.
- Resource – including developing a business case to recruit a dedicated Fast Track and End-of-Life and Palliative Care Occupational Therapist.

It has been identified that improvement work related to use of the ReSPECT form needs increased focus, but this is limited by a current lack of ownership of this area within the Trust.

A programme of ward-based intensive training and support to assist ward staff to deliver excellent end-of-life and palliative care commenced in August 2022. The specialist team aim to rotate to all ward areas over the next 12 months.

8.0 Deaths of patients with a confirmed Learning Disability

8.1 In Q1 2022/2023 there were 4 patients and in Q2 2022/2023 there was 1 patient with confirmed learning disabilities, who died in the Trust 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). All cases from Q1 have received a mandated internal SJR and are currently awaiting the external LeDeR review. The outstanding SJR for the death in Q2 is in progress.

8.2 In collaboration with the Trust Mental Health and Learning Disability Lead there has been a review of the internal processes to ensure the completed SJR is available to support with the LeDeR review. This should facilitate more timely reviews.

8.3 Positive learning was identified in the 4 completed SJRs including:

- Appropriate mental capacity assessments completed.
- Evidence of good communication with the carer who had known the patient for nearly 30 years in the absence of a next of kin.
- Good holistic care and balance between intervention versus risk and quality of life.
- Very good individualised and person-centred decision making.
- Good family support provided.
- Appropriate involvement of the palliative care team and acute liaison learning disability team.

8.4 There was no negative learning identified in any of the 4 completed SJRs. None of these deaths have been reported as a serious incident.

8.5 A quarterly LeDeR update from the Trust Mental Health and Learning Disability Lead has now been introduced as a standing agenda item at the Trust Learning from Deaths group.

9.0 Deaths of Patients with a Serious Mental Health Condition:

9.1 To facilitate appropriate recognition of patients who have died in the Trust with a serious mental health condition and consequently initiate a mandated review of care in line with national guidance (NQB 2017), a review of the internal processes to support this is underway in collaboration with the Trust Mental Health and Learning Disability Lead. There is currently no nominated mental health specialist to support mandated SJRs for this group of patients within the Trust. Until appropriate resource can be identified SJRs for patients who have died with a diagnosed serious mental health condition will be managed through the divisional clinical teams.

9.2 In Q1 2022/2023 there were 3 deaths identified of patients with a serious mental health condition and in Q4 2022/2023 there was 1 death. To date only 1 SJR has been completed.

9.3 Whilst the available learning is limited for this group of patients, no negative learning was identified in the 1 case reviewed. Positive learning identified included:

- Evidence of reviews by the mental health liaison team and involvement of The Redwoods Centre specialist mental health staff.
- Carer was present with patient.
- Appropriate links with safeguarding team made.

10.0 Maternal, Neonatal and Infant mortality

10.1 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’.

10.2 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). There has been one indirect maternal death in Q1 2022/2023 which is currently under investigation and no maternal deaths in Q2 2022/2023.

10.3 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.

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

Term	Definition	SaTH Q1&2 data
Stillbirths	Baby delivered from 24+0 weeks gestation showing no signs of life	8
Early neonatal deaths	Death of a live born baby (20 weeks gestation or later) occurring before 7 days of life	5
Late neonatal deaths	Death of a live born baby occurring between 7 and 28 completed days after birth	0
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	1

10.5 There were no serious incidents relating to maternal deaths and 2 serious incidents relating to perinatal mortality that were reported by the Trust to the Strategic Executive Information System (StEIS) during Q1 and Q2 2022/2023. These are under investigation.

10.6 Divisional reporting to the Trust Learning from Deaths group of mortality data and identified learning from the various review and investigative processes within the Women and Children Division, commences December 2022. This will complement existing governance processes within the Division where mortality data and learning from deaths is currently disseminated.

11.0 Paediatrics

11.1 There were 2 inpatient deaths of children under the age of 18 in Q1 and Q2 2022/2023.

11.2 Three serious incidents relating to child deaths have been reported by the Trust to StEIS during Q1 and Q2 2022/2023. These investigations remain open.

12.0 Potentially Avoidable Deaths

12.1 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.

12.2 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.

12.3 In Q1 and Q2 2022/2023, there was 1 death within the Trust which, following serious incident investigation was determined more likely than not to have been due to problems in healthcare and therefore to have been potentially avoidable. Duty of Candour is completed by the Divisional Quality Governance Teams. Learning from serious incidents is shared as described at section 12.2.

13.0 Other Improvements and developments in the Trust Learning from Deaths agenda

13.1 NICHE Phase 2 Recommendations:

All 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 now complete. The action plan was formally closed through the Trust Learning from Deaths group in November 2022.

13.2 Requirement for acute organisations to extend ME services to provide independent scrutiny for all deaths including the non-acute sector:

With support from the Trust 'Getting-to-Good' programme the rollout for non-acute ME reviews has now been incorporated into a defined improvement project with additional support from NHSE to accelerate workstreams. Reporting for this project is to the Trust Operational Delivery Group and will be completed on a rolling basis. A plan on a page detailing the scope, impact, high level milestones, risks and metrics to measure improvement has been produced, along with a detailed project plan to support the monitoring of workstreams moving forward.

13.3 System Learning from Deaths group:

A System Learning from Deaths group has been established. Terms of reference have been finalised and a schedule of meetings with appropriate membership is being planned.

13.4 Learning from Deaths Sustainability Survey (based on NHS Sustainability Model):

In July and August 2022, an NHSE Sustainability Survey was circulated to SJR reviewers and key stakeholders in the Learning from Deaths programme of work. Only 16 responses were received. Although the response was unfortunately limited, the areas where the greatest potential for improvement was identified were:

- Senior leaders and clinical leaders.
- Infrastructure for sustainability including training, facilities, job descriptions, policies and procedures.

These areas for improvement will be incorporated into the collaborative improvement project described at section 3.17. NHSE have recommended that the survey is repeated in 6 months' time.

13.5 Onsite NHSE external review:

An onsite external assurance review is being facilitated by the NHSE Better Tomorrow programme leads in December 2022. Following an external online review of 60 completed SJRs, a detailed onsite review of 30 of these will take place and a report will be available in the new year. The findings will be utilised to assist the planning and development of local training and quality assurance initiatives.

13.6 New SJRPlus platform:

The current ORIS platform providing access for users to the online SJRPlus tool is being replaced by one that has been developed by NHS Digital. The launch of this is planned for December and will be available via NHS Applications. The Learning from Deaths team have been involved in the development of this tool, providing recommendations for improvements, and participating in user acceptance testing.

13.7 Online Mortality Screening tool:

The pilot phase was completed at the end of May 2022. Due to resource issues and other priority projects within the IT development team, the recommended revisions to the screening tool have been delayed.

14.0 Risk register

14.1 There is one risk on the Trust Risk Register relating to recruitment within the Learning from Deaths.

14.2 The Trust has agreed to recruit at risk to clinical and non-clinical roles within the corporate 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. The Clinical Lead position to support the current Senior Learning from Deaths Clinical Lead is proving particularly challenging and to date, no applications have been received. The vacant position will undoubtedly have a negative impact on the ability to promote and increase SJR completion rate across the Trust.

14.3 Appropriate office space accommodation has not yet been identified to house the expanded Learning from Deaths team.

Trust Senior Clinical Lead for Learning from Deaths
Head of Learning from Deaths and Clinical Standards
Medical Examiner Service Manager
December 2022