The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 13 April 2023

Agenda item	042/23				
Report Title	Learning from Deaths Quarter 3 2022-2023 Report				
Executive Lead	John Jones Executive Medical Director				
Report Author	Fiona McAree, Head of Learning from Deaths and Clinical Standards Roger Slater Trust Senior Clinical Learning from Deaths Lead				
CQC Domain:		**Link to Strategic Goal:**			**Link to BAF / risk:**
Safe	√	Our patients and community	√		
Effective	√	Our people			
Caring	√	Our service delivery	√		**Trust Risk Register id:**
Responsive	√	Our governance	√		435
Well Led	√	Our partners			
Consultation Communication	Trust Learning from Deaths Group, 02 February 2023 Quality Operational Committee, 21 February 2023 Quality and Safety Assurance Committee, 22 February 2023				
Executive summary:	The Board's attention is drawn to five sections within this report: • **Item 1.1 -** There were 629 inpatient and emergency department (ED) deaths in the Trust within Q3 2022/2023, an increase of 126 deaths from Q2 and an increase of 72 from the same quarter 2021/2022. • **Item 1.2** - ED deaths at RSH in Q3 2022/2023 have more than doubled for the same quarter 2021/2022. • **Item 1.7** - Performance in issuing an MCCD within 3 calendar days has deteriorated further in this quarter due to the significant pressure treating clinicians are under. • **Item 1.9** – Timely SJR completion in the Trust remains challenging and significantly below the NHSE recommendation of 15% of all deaths. • **Item 1.12** - Two serious incident investigations presented to the Trust Review Actions and Learning from Incidents Group (RALIG) in Q3 2022-2023 determined that the death was more likely than due to problems in healthcare and therefore potentially avoidable. The risks to the organisation are; • Unable to meet the national target issuing MCCDs within 3 calendar days which also impacts on the bereaved registering a death and public confidence in our services. • There have been insufficient SJRs completed in Q3 to enable any credible analysis of the identified learning and detailed inclusion in				

	this report. This is below the NHSE target and could lead to missed opportunities for learning across the organisation. • Potentially avoidable deaths could lead to litigation for the organisation. We are currently progressing a number of improvement initiatives to; • Support clinicians facilitate timely completion of MCCDs and ensure registration services remain appraised of the situation. • Work collaboratively with the Trust Improvement Hub and PMO teams to develop a programme of work over the next 12 months to improve timely SJR completion rate compliancy. This includes expansion of the team of SJR reviewers including senior nursing staff, evidencing SJR completion within consultant annual appraisals and increasing capacity to train reviewers and disseminate the learning identified.
Recommendations for the Board:	The Board is asked to take assurance from this report, with particular regard to; • A review of deaths within ED at RSH will be undertaken to examine reasons for the sharp increase in Q3. This will include consideration of a potential link with the increased length of time patients are in the department and a review of co-morbidities and reason for attendance. • An assurance review has been undertaken to explore why the SHMI and HSMR indicators have been consistently higher at PRH than RSH and found both hospitals are comparable or favourable to similar peer trusts. • While there has been reduced completion of SJRs, NHSE recommend to focus on quality of completed SJRs which the Learning from Deaths Team endeavour to utilise in order to improve patient outcomes. • The Trust Learning from Deaths Group identified that a review of comparison of mortality associated with acute respiratory conditions may be helpful and this will be explored further. • An external review by NHSE undertaken in December 2022 did not highlight any concerns or potential areas for improvement that the Learning from Deaths team had not already identified and started to address. • The successful recruitment to the Learning from Deaths Clinical Lead post commencing 01 Feb 2023. However, please note the issues highlighted, particularly with regard to the completion of insufficient SJRs and the mitigation in place to increase completion. This summary report should be read in conjunction with Appendix A Full Report which is available in the information pack.

Appendices: (contained within Information Pack)	**Appendix A:** How We Learn from Deaths Quarter 3 2022-2023 Full Report **Appendix B:** Supporting The Shrewsbury and Telford Hospital NHS Trust (SaTH) to assure their mortality review processes and evidence their learning from deaths. NHSE and NHS Improvement (2023).

1.0 Introduction

Summary of Hospital Deaths

1.1 There were 629 inpatient and ED deaths managed by the Medical Examiner Service in the Trust within Q3 2022/2023, an increase of 126 deaths from Q2 and an increase of 72 from the same quarter 2021/2022.

1.2 Appendix A in the information pack provides a detailed overview of total deaths across the Trust over the last 12-months. Whilst the figures for inpatient deaths remain stable, a sharp increase of deaths within the Emergency Department (ED) can be noted, from 73 deaths in Q3 2021/2022 to 139 deaths across both sites for the same quarter 2022/2023. Fig.2 compares inpatient and ED deaths for each site. ED deaths at RSH in Q3 2022/2023 have more than doubled for the same quarter 2021/2022.

Learning from Deaths Dashboard

1.3 SHMI data includes deaths in hospital and those which occur within 30 days of discharge. The Trust's rolling 12-month SHMI for July 2022 is 1.03 which is within expected range and is favourable to the peer group.

1.4 SHMI and HSMR indicators have been consistently higher at PRH than RSH. An assurance review has been undertaken to explore this further, the findings of which were presented at the Trust Learning from Deaths Group and are summarised further in Appendix A. The Trust should be assured that while SHMI and HSMR are higher at PRH during the period under review, both hospitals are comparable or favourable to similar peer trusts.

1.5 The Trust Learning from Deaths Group have identified that a review of comparison of mortality associated with acute respiratory conditions will be helpful and this will be explored further.

Medical Examiner Service

1.6 Of the 629 deaths that occurred in Q3, the Medical Examiner (ME) Service independently scrutinised 628, with 1 death referred directly to the coroner. 139 deaths were referred to the coroner following ME Scrutiny. However, performance in issuing an MCCD within 3 calendar days has deteriorated further in this quarter due to significant pressure treating clinicians are under. The Bereavement Team continue to support the clinicians to facilitate as timely completion as possible and ensure registration services remain appraised of the situation.

1.7 In Q3 2022/2023, 22 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 has been investigated by the relevant division and two are subject to a Coroner's

inquest, the learning of which will feedback through the Legal Team. Six cases are progressing through the formal complaints process at the time of this report.

Completion of Structured Judgement Reviews (SJRs)

1.8 Whilst the SJR completion rate for Q4 2021/2022 is now near to the NHSE target of 15%, the completion rates over the last three quarters demonstrate significant deterioration. The reason for the deterioration in SJR completion is believed to be multi-faceted and detailed in Appendix A.

1.9 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.

Overview of Care

1.11 A high-level overview of care is provided on the dashboard however, there have been insufficient SJRs completed in Q3 to enable any credible analysis of the identified learning and detailed inclusion in Appendix A.

Potentially Avoidable Deaths

1.12 In Q3 2022/2023, there were 6 serious incidents relating to patients who have died, reported externally to the Strategic Executive Information System (StEIS). Following serious incident investigation, two deaths within the Trust presented to RALIG in Q3 2022/2023 were deemed 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.

Covid Update

1.13 There have been 185 patients who have died with definite/probable hospital onset COVID-19 in Q3. Over the past 12 months these correlate to an average of just over 4 patients per month who have died in relation to nosocomial infection where Covid-19 is on the death certificate. Prior to the vaccination roll out, this was significantly higher.

1.14 While the focus of the Trust's Serious Incident review complies with the requirement to investigate those patients who died due to probable/definite acquired Covid-19 infection, a holistic approach is being taken to the management of Covid-19 across the organisation and consideration given to internal, external, and human factors which have affected this.

1.15 While there is evidence that there may be some lapses in Infection, Prevention and Control (IPC) compliance in some areas which may have contributed to the outbreaks, which can lead to subsequent deaths of patients, this is not the only factor, these are listed in Appendix A.

Formal feedback from onsite NHSE external assurance review completed December 2022

1.16 An external peer review of the quality of the Trust's SJRs and the way it can use these to learn from deaths and improve care was undertaken in December to assure the Trust about SJR skills and processes and identify any areas for improvement. The formal report received at the end of January 2023 did not highlight any concerns or potential areas for improvement that the Learning from Deaths team had not already identified and started to address. The summary of findings can be found in Appendix B. Th report was shared at the Chief Executives Meeting 28th March 2023.

Risk register

1.17 There is one risk on the Trust Risk Register relating to recruitment within the Learning from Deaths however, the Trust has agreed to recruit at risk to clinical and non-clinical roles within the corporate Learning from Deaths team and additional PA 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.

2.0 Recommendations

2.1 The Board of Directors is asked to review and take assurance from this report and note the findings and progress made to improve the learning from deaths and medical examiner agenda.