The Shrewsbury and Telford Hospital NHS Trust

Board of Directors'
Meeting 8 June 2023

Agenda item	064/23			
Report Title	**Appendix A -** How We Learn from Deaths Quarter 4 and Annual Report 2022-23			
Executive Lead	Dr John Jones, Executive Medical Director			
Report Authors	Dr Roger Slater, Senior Clinical Lead for Learning from Deaths. Fiona McAree, Head of Learning form Deaths and Clinical Standards.			
	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 assurance	√		
	For approval	√	Link to risk register: ID435	
Presented to:	Trust Learning from Deaths Group, 4th May 2023 Quality Operational Committee 16th May 2023 Quality and Safety Assurance Committee 31 May 2023			
Executive summary:	• There have been 2282 inpatient and emergency department (ED) deaths managed by the Medical Examiner Service within the Trust during 2022-23, an increase of 179 deaths compared to 2021-22. Of these deaths 626 occurred within Q4. Deaths occurring within the Emergency Department (ED) remain high compared to 2021-22. One reason that may contribute to this is that the data shows an increased Hospital Occupancy well above the threshold for both Q3 and Q4 2022-23 compared to the same reporting period. An assurance review is underway to explore further the increased number of deaths that have occurred in ED during 2022-23 and the findings will be reported to the Learning from Deaths Group, Quality and Safety Assurance Committee and the Trust Board. • The Trust's latest SHMI for October 2022 was 102.84 which is within the expected range and is favourable to the peer group. • A targeted focus on the completion of Structured Judgement Reviews (SJRs) has been undertaken leading to an increase in completed SJRs in Q3 from 0.8% to 3.1% since the last report was presented to the Board of Directors and 2.7% of deaths have now been reviewed in Q4. Overall, SJRs have been completed for 3.4% of all deaths across the Trust during 2022-23. • One serious incident investigation presented to the Trust Review Actions and Learning from Incidents Group (RALIG) in Q4 determined that the death was potentially avoidable due to problems in healthcare.			

Appendices	A: Medical Examiner and Bereavement Service Report Q4/Annual B. Glossary of terms C: Overview of Trust Learning from Deaths Dashboard D: Causes of Death relevant to completed SJRs 2022-23
Executive Lead	Dr John Jones, Executive Medical Director

1.0 Summary of Hospital Deaths

1.1 There have been a total of 2282 inpatient and emergency department (ED) deaths across the Trust during 2022-23. This is an increase of 179 deaths compared to 2021-22. Of these deaths, 626 occurred within Q4, which is a reduction of 3 deaths (623) as reported in Q3, however an increase of 130 deaths from the same reporting period in 2022.

1.2 The number of deaths that occurred in ED across the Trust during Q4 remains high when compared to the same reporting period in 2021-22. One reason for this is that the data shows an increased Hospital Occupancy well above the threshold for both Q3 and Q4 2022-23 compared to the same reporting period. An assurance review is underway to explore further the increased number of deaths that have occurred in ED during 2022-23. On completion, the findings from this review will be presented to the Trust Learning from Deaths group and escalated to the Quality Operational Committee and the Trust Board thereafter. Further detail of work being undertaken to review this is provided at section 2.9.

2.0 Learning from Deaths Dashboard

2.1 A visual overview of the dashboard is provided at Appendix B highlighting key metrics relating to:

- Context around learning from deaths including SHMI
- Medical Examiner Scrutiny to SJR
- High level details relating to care.

2.2 Summary Hospital-level Mortality Indicator (SHMI):

The Trust's SHMI for October 2022 is 102.84 which is within expected range as shown at Fig. 1 and is favourable to the peer group as per Fig. 2 below.

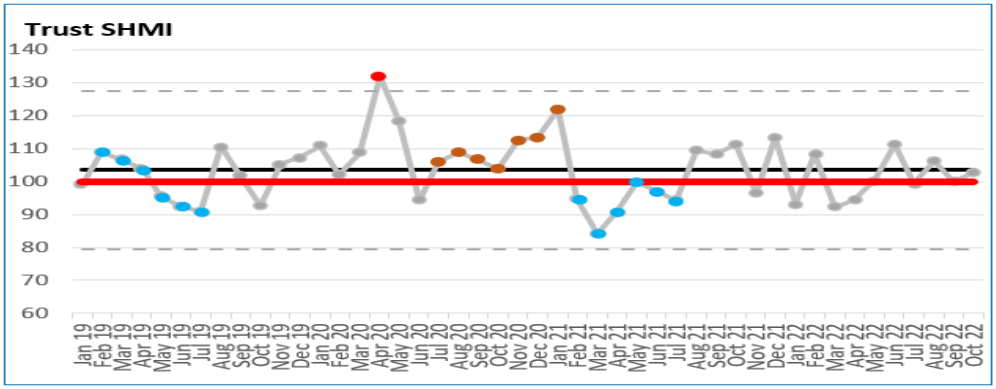


Fig. 1 Trust SHMI (Source: Learning from Deaths Dashboard)

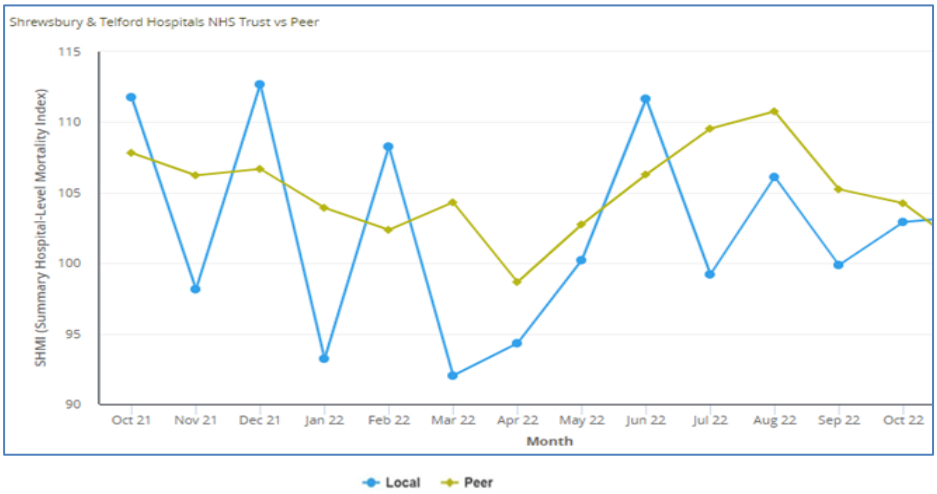


Fig. 2 Trust SHMI vs. Peer (Source CHKS)

Figure 3 shows the Trust SHMI position in relation to the peer distribution.

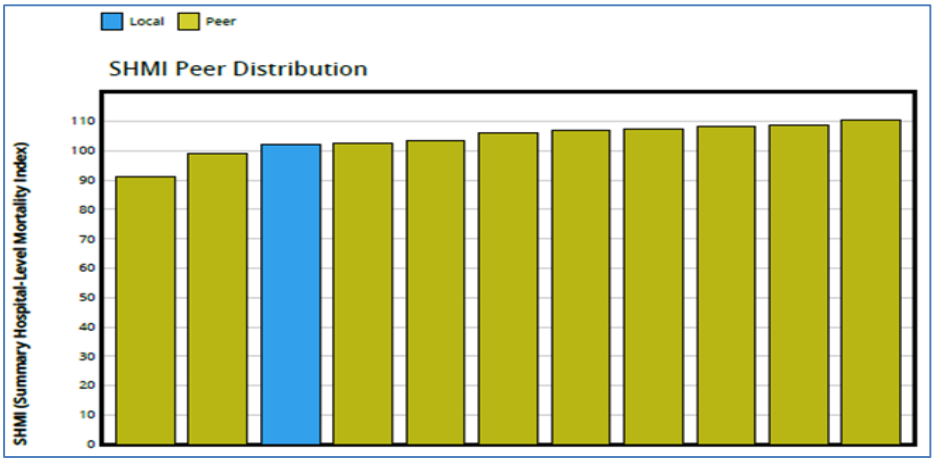
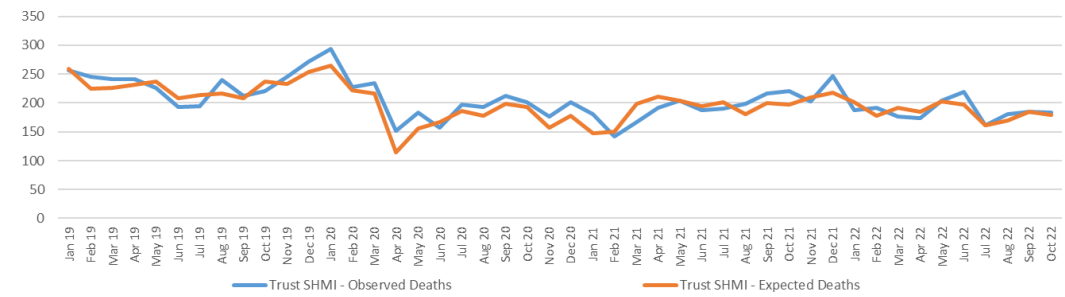


Fig. 3 SHMI Peer Distribution

2.3 SHMI Observed versus expected deaths:

The trend for observed versus expected deaths is monitored through the Learning from Deaths Dashboard and is shown at Figure 4. Observed deaths are largely comparable to expected deaths for the current time period.

Fig. 4 Trust expected deaths Vs. observed deaths



2.4 Mortality by site / Risk Adjusted Mortality Index (RAMI)

A summary of the findings from an assurance review undertaken earlier this year to explore the consistently higher mortality at PRH compared to RSH, was detailed in the Q3 2022-23 report. The review identified that it may be useful to specifically include

analysis of the RAMI model, to compare mortality between the two sites as a potentially more appropriate model to utilise for future comparison between both hospitals. RAMI is more comparable between the two hospitals than HSMR and SHMI, with non-elective medicine and emergency patients having a lower RAMI at PRH than at RSH, unlike the other indicators. This is likely due to the risk adjustment made by the RAMI model for the longer lengths of stay recorded at PRH, which helps to mitigate some of the differences in case mix between the hospitals. The crude mortality by bed day rather than by spell also shows a more similar position at the two hospitals.

The Trust's RAMI position remains consistently below the peer group (Figure 5) although demonstrates an increasing trend for SaTH overall and the peer (Figure 6). RAMI is generally slightly higher at PRH than RSH, and whilst it has been higher for the last two months of December and January, assurance can be taken as the index remains below 100, below the peer for both hospitals and the increase is in line with the peer group over the winter months. The increase in RAMI is related to an increase in observed deaths, with a specific increase in the condition groups pneumonia and influenza at PRH.

Further assurance can be taken that RAMI, as part of the wider CHKS reporting is monitored as a standard agenda item during the Trust Learning from Deaths group and as such, this increase will remain under close monitoring.

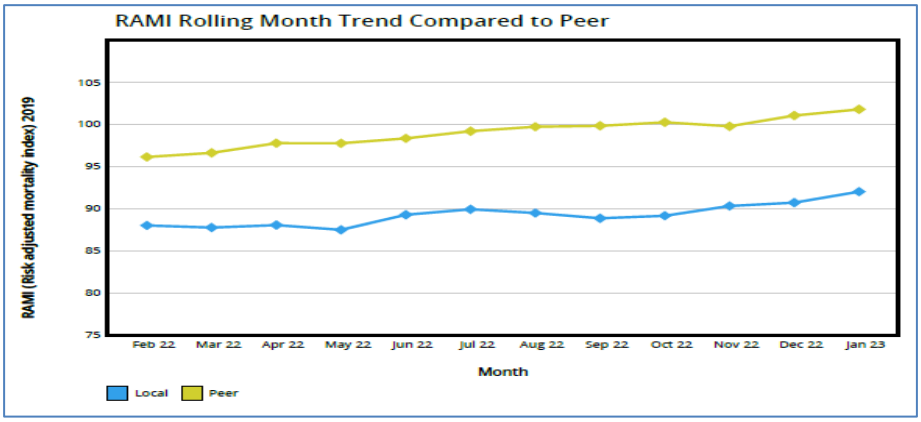


Fig. 5 RAMI Rolling Month Trend to Peer

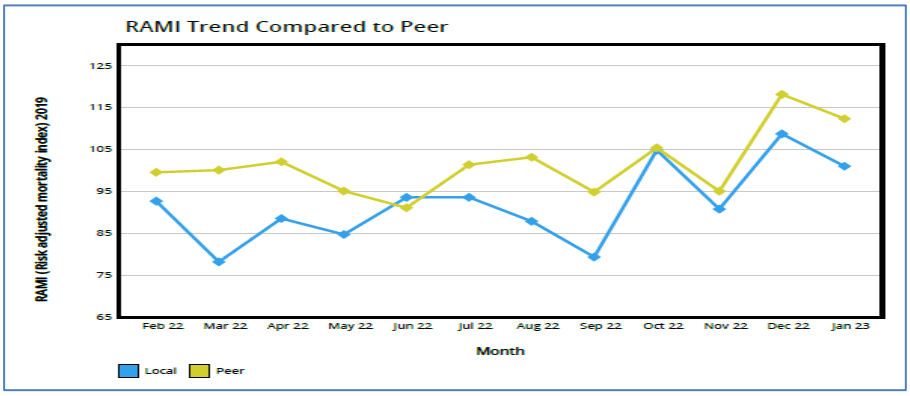


Fig. 6 RAMI trend to peer

Following the review undertaken to compare mortality by site, a further review was advised to factor in local knowledge of differences in patient case-mix and services provided at each hospital and provide further comparative analysis on more specific cohorts of patients. Discussion within the Trust Learning from Deaths Group identified that further comparisons of mortality associated with both acute respiratory and cardiac conditions may be helpful. Service provision across both hospital sites should

be comparable for patients with respiratory conditions whilst it was anticipated that mortality associated with cardiac conditions at PRH, would be higher than RSH in recognition that the cardiology service is based in Telford.

The additional review undertaken by CHKS was presented to the Trust Learning from Deaths group in April 2023. No specific concerns were identified as a result of this subsequent review and as such, the Board can take assurance from the findings as detailed below.

Only non-elective patients and those aged 18 or over were included in this review. The activity period used was October 2021 to September 2022, in line with the latest available SHMI data at the time of the review.

Respiratory patients:

- Crude mortality by hospital for emergency adult respiratory patients was similar against comparable levels of activity.
- SHMI performance showed a similar observed rate of death between both hospitals, but a lower 'expected' mortality rate at PRH than RSH, which consequently resulted in a higher SHMI at PRH.
- RAMI performance also showed a very similar position to SHMI for the two hospitals, with a lower 'expected' rate and therefore a higher RAMI index for PRH to RSH.
- The average age of respiratory patients at PRH was lower than at RSH, which will impact on the risk scores therefore giving a lower number of 'expected' deaths. There was also a shorter average length of stay at PRH which again slightly impacts on the RAMI risk scores and consequently the number of expected deaths.
- The average number of diagnosis codes recorded per patient was found to be lower at PRH to RSH as well as a lower average Charlston comorbidity score from these diagnoses, both of which will contribute to lower risk scores being assigned by the models. This may be representative of differences in case-mix and acuity of patients attending both hospitals, but Trust was advised to seek further reassurance regarding clinical documentation in patients notes which directly impacts clinical coding.
- The Board of Directors is asked to take assurance that the Clinical Coding Team validate all deceased records for accuracy prior to external submission of the data and as a result, have confidence that all available codes have been entered for the available clinical documentation. The Clinical Coders regularly attend specialty governance meetings across the Trust to raise the profile of the direct impact of clinical documentation on coding. A review of this involvement is planned by the Clinical Coding Manager to ensure learning opportunities aimed to improve clinician awareness of coding are maximised. To provide further assurance regarding the lower level of coding at PRH to RSH, an additional piece of work is planned by the Clinical Lead for Learning form Deaths to review coding in collaboration with the Clinical Coding team to identify any additional learning opportunities which can be incorporated into wider training and support of clinicians.

Cardiology patients:

- The levels of activity at each hospital for emergency adult cardiology patients was similar however the mortality rate was as predicted, found to be higher at PRH than RSH.
- The RAMI model showed a higher observed rate of deaths and a higher 'expected' number of deaths / higher 'expected' mortality rate at PRH and the RAMI was slightly higher at PRH than RSH, but assurance can be taken as the RAMI at both PRH and RSH were well below 100, indicating fewer deaths than expected by the model.
- The average age and level of coding was very similar between both hospitals. Patients stay for longer at PRH to RSH and as a result this will increase the expected mortality rate for PRH using the RAMI model.

2.5 SHMI Details by Condition (Source CHKS):

In the latest available CHKS report, the primary diagnosis conditions with the highest number of 'excess' deaths across the Trust are:

- Acute cerebrovascular disease
- Anaemia
- Acute and unspecified renal disease

2.6 Deaths where acute cerebrovascular disease is the primary diagnosis code:

The care provided to all patients who die at PRH under the care of the Stroke Team is reviewed and subsequently discussed by the multi-disciplinary team at Stroke Governance meetings. An additional review is underway between the Learning from Deaths team and the Stroke Consultants, relating to patients who died at RSH with a relevant Cause of Death to identify additional learning opportunities. The outcome of this review will be fed back to the Trust Learning from Deaths group when it has been concluded and progress is being monitored through the action tracker.

2.7 Deaths where anaemia is the primary diagnosis code:

To support a clinical review undertaken in 2022 and in recognition that this condition remains one of the top three primary diagnoses with the highest number of excess deaths in the Trust, an additional review has been undertaken by the Clinical Lead for Learning from Deaths using the SJR methodology.

There were 26 cases in the cohort, 14 at RSH and 12 at PRH. 18 of these patients received a blood transfusion, 2 had a treatment plan for a transfusion but deteriorated prior to this being given, and 2 patients received other treatment. Following a high-level review, 8 randomly selected cases were subject to detailed case record review. In all cases, the management of the patient was deemed to be appropriate with timely blood tests and plans for transfusion, therefore no specific concerns could be identified within this specific cohort of patients.
Deaths where anaemia the primary diagnosis code will continue to be monitored by the Learning from Deaths team and a further case record review may be repeated if

this condition continues to be one of the top three primary diagnosis codes with the highest number of deaths in the Trust.
NHS Digital provides SHMI data and provides further information that, of the 26 deaths, 9 were in hospital and 17 were out of hospital, within 30 days of discharge.

2.8 Deaths where acute and unspecified renal disease is the primary diagnosis code:

Acute Kidney Injury (AKI) is a common condition (1 in 5 emergency admissions) associated with high mortality (20% within 30 days of diagnosis) and morbidity (1 in 5 sustain further AKI). 1 in 6 patients develop chronic kidney disease (CKD) and over the year following AKI, 1 in 4 patients sustain a major adverse cardiovascular event. AKI is also associated with high rates of unplanned readmissions (1 in 5 within 30 days and 1 in 3 within 90 days). Improving AKI care is a key recommendation of several Get It Right First Time (GIRFT) reports and has been adopted as one of the high impact changes of the renal services transformation programme.

A specialist nurse led intervention and education programme at Central Manchester University Hospitals NHS Foundation Trust has demonstrated in a peer-reviewed study, a reduction of length of stay by 23%, time to recovery from AKI by 36%, hospital-acquired AKI by 28% and a trend towards reduction of AKI related deaths by 10.5%. Using this data, a number of hospitals in the West and East Midlands have submitted successful business cases and developed specialist nurse led AKI intervention and educations teams. Benefits for AKI patients in the form of reduction in AKI-associated SHMI and reduction in length of hospital stay are starting to be realised by these hospitals.

SaTH has been highlighted as an outlier for mortality as regards acute and unspecified renal failure. One of top 3 HSMR, SHMI and RAMI conditions with highest number of excess deaths at both RSH and PRH – higher than the peer average and increased from previous year (period reviewed September 2020 to August 2021). Studies done at SaTH over the years have demonstrated a 38.7% mortality in patients with AKI stage 3, incomplete recovery of renal function in 28% and requirement for dialysis and the high associated costs in 3%.

The renal team strongly recommend that SaTH commit to develop a nurse led AKI intervention team in order to improve care received by these multi-morbid patients in an attempt to reduce AKI associated mortality and morbidity. The Board of Directors is asked to consider this recommendation.

2.9 Deaths that occur within the emergency department:

The Q3 2022-23 report identified an increase of deaths occurring within the emergency department across the Trust, with the figures almost doubling for the same period in 2021-22. This increase is also reflected within the crude mortality performance relating to the percentage of unplanned attendances who died in the emergency department between February 2022 and January 2023, as flagged within the latest CHKS report.

A review is underway involving senior clinicians from the Medicine and Emergency Care (MEC) Division, the Quality Governance Team, and the Corporate Learning from Deaths Team. Initial plans to progress the review include:

- Split the review of care for the patients within the cohort into those who were under the care of emergency department consultants and those who were under the care of a non-emergency department consultant.
- Exclude patients who arrived in the department in cardiac arrest or those who arrived peri-arrest, unless there is an ambulance delay involved.
- Review timings associated with ambulance arrival and offload.
- Review timings relevant to ambulance offload and subsequent review in the emergency department.
- Review timings relevant to emergency department clinician review and decision to admit (DTA).
- Review timings from DTA to specialty team review.
- Review the total time the patient spent in the emergency department, from arrival to death.
- Undertake a deep dive review of cases where the death was related to sepsis and infection with a focus on the care provided both within the emergency department as well as on-going care, including compliancy with the sepsis pathway, antibiotic administration, and fluid management.

On completion, the findings from this review will be presented to the Trust Learning from Deaths group and escalated to the Quality Operational Committee thereafter.

2.10 Medical Examiner Scrutiny:

A summary of Medical Examiner Service activity is detailed in the attached Medical Examiner and Bereavement Service report Appendix A.

2.11 Completion of Structured Judgement Reviews (SJRs):

SJRs may currently be triggered in the Trust through ME Scrutiny, online mortality screening or following case discussions within the weekly Mortality Triangulation Group operational meeting. Random sampling of cases for SJR from deaths that have not been triggered for SJR via any other source, has also now been introduced to provide additional assurance for the Trust.

At the time of writing this report, the percentage of deaths in each quarter during 2022-23 which have received an SJR has increased in line with Figure 7 below. Orange represents the percentage when the Q3 report was written for presentation at the Trust Learning from Deaths Group in February 2022. Blue provides the current figures. The overall percentage of deaths over the 12 months in 2022-23 that have received an SJR equates to 3.4%. A further 3.3% of deaths which were initially flagged for SJR, were or are being managed through additional processes as appropriate, for example, serious incident investigation, datix review, sepsis validation or coronial proceedings.

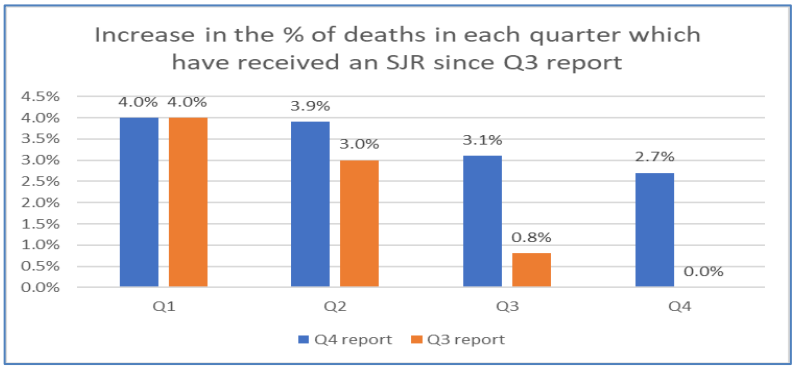


Fig. 7 Comparison of completed SJR (%) between Q3 & Q4 2022-23

A targeted approach is being used to increase the number of SJRs being completed by appropriate senior multi-disciplinary clinicians across the Trust. Two senior nurses have recently joined the team on an ad hoc basis through Temporary Staffing and efforts are being made to identify other appropriate nurses or allied health professionals who may be interested, without depleting resource from the permanent workforce. Other innovative ways to facilitate additional medical support for completing SJRs are also being explored in collaboration with the Medical Director and Deputy Medical Director. SJR completion rates will be available to evidence within consultant, specialty and associate specialty doctors' appraisals.

Whilst continued and sustained effort is made to increase SJR completion rates to facilitate appropriate identification of themes and trends relating to the learning from deaths agenda, additional assurance may also be taken that all deaths within the Trust undergo Medical Examiner Scrutiny (or direct referral to the Coroner in defined circumstances), and that over the year 2022-23, nearly 53% of all deaths have undergone additional independent online mortality screening by the clinical teams following Medical Examiner Scrutiny. This provides further opportunities to identify and disseminate specific learning either within the Trust or across the integrated care system where appropriate, even when cases do not proceed thereafter to SJR. The Trust Mortality Triangulation Group (MTG) maintains oversight of all deaths across the Trust and facilitates triangulation of all learning relevant to patients who die within the Trust as detailed at section 5. Processes have been established to ensure coordination with relevant stakeholders both internal and external to the Trust to maximise all learning opportunities arising out of the wider learning from deaths agenda, rather than being limited to the themes and trends arising from SJR completion alone.

3.0 Patient Profile: Review of SJRs completed during 2022-23

3.1 This section of the report presents a profile of the overall patient cohort for SJRs completed within 2022-23. The final number of completed reviews was 78 although unfortunately only data for 73 reviews have been automatically imported in the generation of this report. This discrepancy has been escalated to NHSE for investigation but as a result, the charts generated and included within this report are largely based on 73 SJRs.

3.2 Age:

Figure 8 provides a breakdown of the age of the patients reviewed, when they died. The majority of SJRs completed within 2022-23, were for patients between 60 and 89 years old, with a smaller proportion of SJRs completed for patients under 50 and over 90 years old. The age of the deceased was recorded in all SJRs, with the age

group 70–79-year-olds accounting for nearly 33% of the cohort, followed closely by the 80–89-year-old age group at just over 27%.

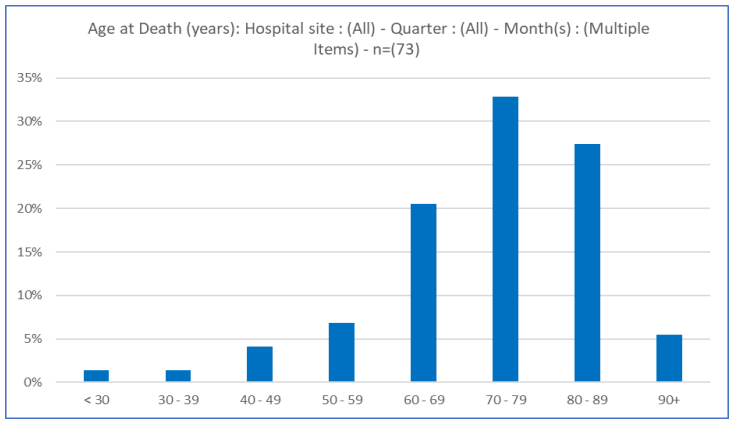


Fig. 8 Age at death

3.3 Ethnicity:

Unfortunately, ethnic group was available in only 20 completed SJRs during 2022-23. The findings therefore do not provide an accurate representation of ethnicity within the cohort of patients where an SJR was completed during this year The low numbers are in line with the findings of the NHSE external review which was presented to the Trust Board of Directors within the Q3 report.

Since the online platform migrated to the new NHS Digital platform in December 2022, ethnicity is available as a picklist option, however this question remains non-mandatory for reviewers. To provide a more reliable summary of the ethnic group of patients reviewed, the Trust will need to increase awareness among reviewers of its importance. A focus on this will be included as part of a wider training initiative when the Learning from Deaths team deliver two SJR Masterclasses later this year.

Reviewers completing the online SJRPlus may access the Trust Clinical Portal to support a review of the physical hospital records. Ethnic group is not currently available for review on the Clinical Portal, which may have a negative impact on the likelihood of this metric being accurately identified within the SJR in the future.

3.4 Length of stay:

Figure 9 below shows the length of stay for the deaths reviewed within 2023/2023. Around 63% patients died within the first 13 days of their stay. Figure 10 shows the length of stay by day for those who died within the first 2 weeks. Around 30% of patients died either on the day of admission or on day 1.

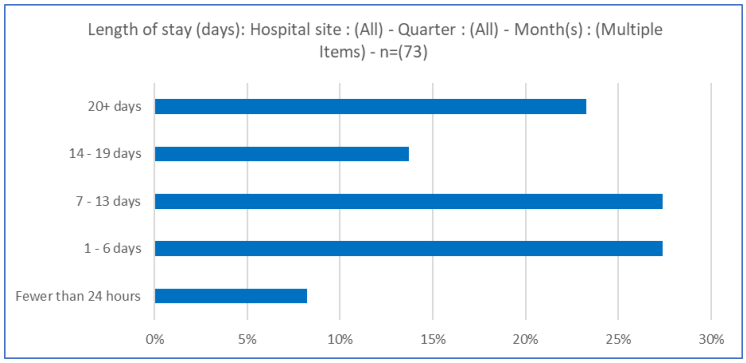


Fig.9 Length of stay

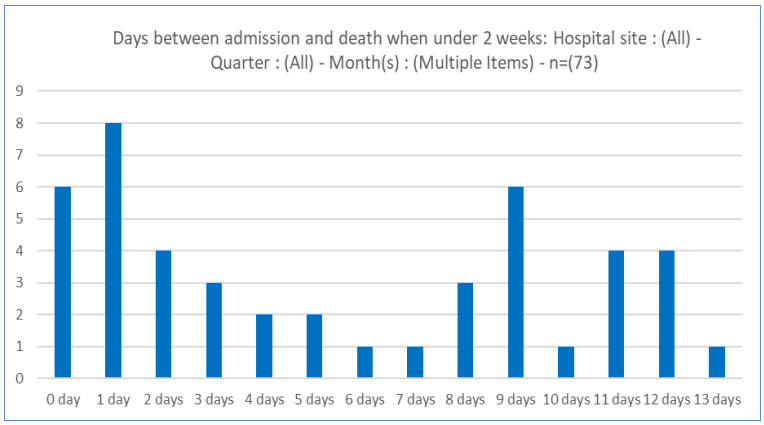


Fig. 10 Number of days between admission and death

Figure 11 demonstrates that the number of deaths during 2022-23 is slightly lower for patients admitted on a Saturday and that slightly more patients died midweek on a Wednesday or Thursday. Performance relating to the day of admission and the day of death is monitored through the CHKS quarterly reporting. Currently there are no identified concerns with either of these metrics.

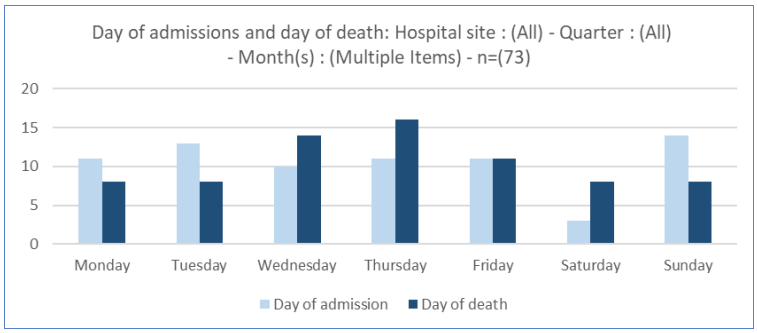


Fig.11 Day of admissions and day of death

3.5 Location patient was admitted from / readmissions:

The vast majority of patients in the cohort, 91.3% were admitted from their own home. See Figure 12.

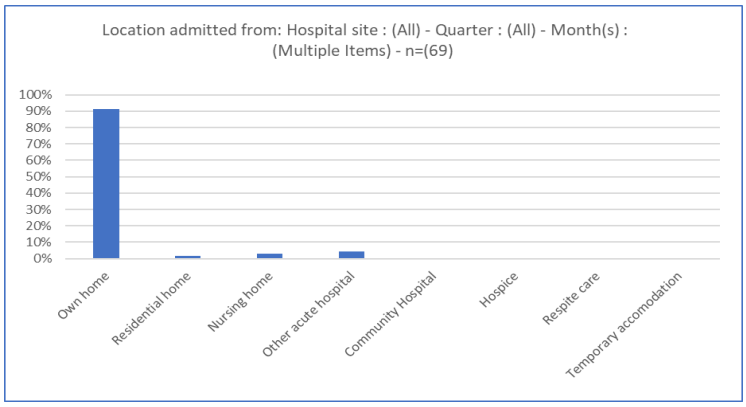


Fig. 12 Location patient admitted from

Ten of the patients reviewed had been readmitted within 30 days of a previous discharge.

3.6 Significant mental Illness and learning disability:

The identification of significant mental illness and learning disability by reviewers within the SJR is potentially subjective and therefore figures may differ to those identified within Sections 6 and 7. Based on the completed SJRs, 10 patients within the cohort were described as having a mental health issue and 9 patients were identified with a learning disability.

3.7 Confusion and memory problems:

The external NHSE assurance review completed in December 2022 highlighted that the number of patients with confusion / memory problems including delirium, during their stay (as identified within the cohort of patients relative to this specific review), was comparatively lower in SaTH (16.7%) than in other Trusts (30.1%). A recommendation was made at this time that the Trust may want to consider whether this lower percentage related to SJR case selection or whether there was a need to improve the way that clinicians recognise and record delirium.

Analysis of all SJRs completed within 2022-23, demonstrates that the percentage of patients who showed signs of confusion, including delirium is now in line with the benchmarked figure and equates to 39.7%, indicating slightly higher number of patients with confusion / memory problems including delirium within the year. Since December 2022, the Learning from Deaths team have undertaken a considerable amount of work to refine SJR case selection which may have started to be reflected in these figures, whilst wider improvement work within the Trust relating to the identification of new confusion may also have had a positive impact.

3.8 Cause of Death:

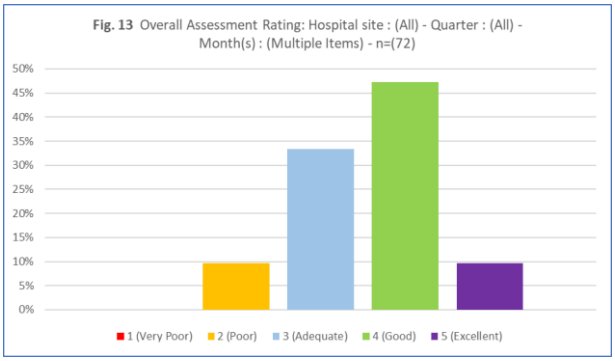
The cause of death was recorded in 77 SJRs as provided at appendix D.

4.0 Judgements and ratings provided for 'Overall Care' and all 'Phases of Care' in completed SJRs within 2022-23

A high-level overview of care for SJRs completed during 2022-23 is provided on the Learning from Deaths Dashboard at Appendix C.

4.1 Overall Care Rating:

The care provided to patients in nearly 57% of all SJRs completed within 2022-23, was rated as 'Good' or 'Excellent' overall as per Figure 13. Care was rated as poor in nearly 10% of all completed SJRs in this timeframe. One case was not rated. No care for cases within the timeframe were rated overall as 'Very Poor'.

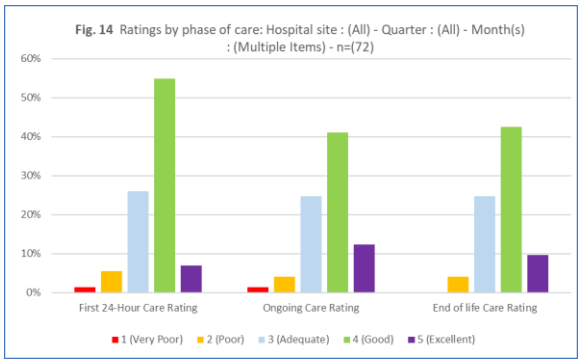


SJRPlus invites reviewers to provide a rating for four specific phases of care during the patient's admission prior to their death:

- First 24 hours
- Ongoing care
- Care during a procedure
- End of life care

Not all phases of care will be relevant to all patients, for example those who die in the first 24hrs or those who do not undergo a procedure during their admission. Fig. 14 shows the distribution of ratings for each phase of care.

A summary of the justifications provided by reviewers for ratings of 'Excellent' or 'Good' care versus 'Poor' or 'Very Poor' care for all four phases of care is provided below.



4.2 First 24-hours Rating:

Care was rated as 'Good' or 'Excellent' within the first 24 hours in 61.6% of cases throughout the year. This represented 45 SJRs. Examples of the reviewers' comments to justify this rating include (as transcribed):

- In ED for several hours, awaiting COVID positive bed, however all appropriate care provided.
- 81-year-old lady admitted from (…) following a collapse. Found to be hypoxic and tachypnoeic on admission, apyrexial, borderline hypertension. ED medical review within 1 hour and medical IM3 review within 2 hours.
- Treated with IV fluids and IV antibiotics within 1 hour of admission to ED – nurses aware that he was very unwell and contacted next of kin to visit. Regular observations recorded and multiple escalation to medical staff recorded. Chest physiotherapy performed in ED several times. Advanced care plan…in place and available via SEMA – printed out and available for staff. Clear communication with family. ReSPECT form rewritten as not brought in by the patient.
- 'This is me' passport in place due to dementia.
- Good overall care despite ambulance offload delay of 6 hours, evidence of good assessment and care whilst in the ambulance including diet and fluid provided.
- Appropriate and timely assessment and treatment in ED. Good communication with (…). Reviewed by ITU Consultant and MDT discussion,

including the family regarding escalations of care. Care plan provided from community and referred to in assessments.

- Seen by Dr within 1 hours of arrival. Sepsis pathway completed, IV fluids and IV antibiotics given.
- 3-hour ambulance offload delay but observations taken whilst on ambulance. Once in ED all appropriate diagnostics undertaken. Appropriate assessments and treatment plans commenced. ReSPECT form completed with patient. Good care despite delay in offload.
- Excellent and timely assessment by medical team. Prompt and appropriate conversations with haematology who reviewed on day of referral.
- Comprehensive geriatric clerking.
- The department had been pre alerted so the full cardiac arrest team were present on arrival. Cardiac arrested 3 hours prior to arrival to ED. Cardiac arrest management continued until enough evidence had been gathered to make a decision to stop the resuscitation. Documentation clearly described unanimous rationale to stop the resuscitation. Documentation clearly describes the conversation with her family. Nursing documentation complete.

Care provided in the first 24-hours of a patient's admission to hospital was rated as 'Poor' or 'Very 'Poor' in 6.9% of SJRs completed during the year. This equates to 6 SJRs. Examples of the reviewers' comments to justify this rating include (as transcribed):

- This patient had known CML with a very high white blood cell count. There was a prolonged delay in this patient being seen and reviewed at the point of presentation to emergency care at PRH.
- Admitted via Emergency Department to resus. EWS 7. Waited for 2 hours to see doctor and a further 30 minutes for IV antibiotics. Notes of ED doctor incomplete - nothing documented after writing PMH. Reviewed by medical doctor at 02:00 hours. Husband present as language barrier and patient agitated due to hypoxia. Not tolerating oxygen therapy well. Haloperidol IM administered to help make patient comfortable. MCA and BI form to provide medical and nursing care. Recorded observations did not meet NEWS2 guidance especially to reflect sedation. Limited information concerning nursing assessments especially pressure areas. Documented that pressure areas intact on admission but then broken area on handover document. Long stay in ED - around 36 hours.
- Inadequate dose of IV frusemide when seen by Med CT trainee around 18:00hrs. Did this doctor understand how sick the patient was?
- Respect form not completed by medics when Renal Cons had asked. Medical issue
- Severe Met acidosis not documented (? recognised by medical junior)
- Bloods not repeated for K until 8am the following day when in ICU when K was 7.0mmol/L - I would have expected they would have been re-done to check the K at least every 6-8hrs after the 1st dose of insulin / dextrose -
- Plan to transfer this patient across to the RSH ICU seemed inappropriate as he was very sick and likely to be too unstable - ICU issue

- 8.4% bicarbonate would seem better to restore pH in this situation of critical illness, not the renal dose 1.26% - ICU issue
- Delay in admitting the patient to the PRH ICU and starting emergency RRT treatment for hyperK (patient had already arrested) - ICU issue
- Patient admitted via medical intake. Scant history documented on medical clerking, but appropriate initial investigations and management commenced. No clear consultant review in the first 24 hours - med reg only. Hypercalcaemia present on admission bloods but not noted or acted upon for 5 days.
- Delays in care due to ambulance offload delays of 6 hours. Poor care initially - delay in review and administration of IV antibiotics and diagnostics for potential sepsis.

4.3 Ongoing Care Rating:

There were 39 SJRs over the year where the ongoing care provided was rated as 'Good' or 'Excellent', equating to 53.4% of all relevant SJRs. Examples of the reviewers' comments to justify this rating include (transcribed as written):

- Full nursing care given on the wards. Regular medical reviews and family updates. Family allowed to remain at the bedside as he continued to deteriorate.
- Post operative period- patient had daily reviews including consultant reviews on most of the days and update with family also noted. There were episodes of confusion which has been documented during this admission. Blood investigation showed low electrolytes (Na, K) which was discussed with the medical team and appropriate management as per the medical team advise. Also, early post-op period there was abdominal distension which was appropriately managed with NG tube insertion. Further documentation showed patient started passing flatus and opened…. bowels as well and distension improved. Patient was allowed normal diet as tolerated... Patient became acutely unwell with NEWS of 5, tachycardia, tachypnoea and requiring oxygen. Urgent review undertaken by registrar…. Appropriate management as expected for an acutely unwell patient was undertaken with fluid resuscitation, blood investigation including blood gases and CT scan was organised. CT scan at 0524, suggested anastomotic leak. Findings informed to consultant and urgent review by consultant…noted. As the patient was very unwell by then, decision was for emergency surgery, which was also discussed with the on call CEPOD consultant. Risk about return to theatre has been documented in the notes and consent form and also discussed with daughter. Post-op patient was still very unwell, transferred to ITU on ventilator and on increasing dose of inotropes. Consultant spoke to daughter and explained about the operative findings and general condition of the patient. Patient continued to be quite unwell, in spite of maximum support and was deteriorating. Discussion undertaken by ITU doctor and family and decision was made to withdraw treatment.
- Excellent - daily review. Excellent- escalation to Med SpR for review? AIRVO due to deterioration with new oxygen requirement. Excellent- discussion with patient, wishes full escalation. Current ward could not offer AIRVO. Excellent-

escalated to ITU, who felt not appropriate due to age and co-morbidities. Suggested resp. team review. Excellent- tried to make contact with wife. Good- ruled out sources of active bleeding. Excellent – resp. review, prognosis guarded, aim to move to resp. ward for AIRVO dependent on bed availability.

- Excellent communication with husband concerning his wife's admission and prognosis.
- Great communication and timely intervention by all the specialities involved in care. This was a complex case with good cooperation seen throughout the ongoing care. Excellent documentation. Good practice throughout.
- Admitted to ward and seen regularly by doctors from different specialities. Good documentation and timely investigations. Clear involvement for patient in his care and frank conversations about his condition and prognosis were commenced. Nursed noticed deterioration in his condition and escalated appropriately with medical review. Later referred to ITU as increased oxygen requirement.
- Once in ITU documentation was very good and patient continued to be involved in his care and treatment with his views and wishes considered. As his condition deteriorated this was explained to his family. Regular consultations and advice taken from microbiology and the cardio thoracic surgeons. As condition deteriorated further his family were involved with decisions to withdraw treatment.

There were four cases during 2022-23 where the reviewer rated the ongoing care as ‘Poor’ or ‘Very Poor’ equating to 5.5% of the relevant SJRs. The concerns raised related to:

- Incomplete medical entries in notes.
- Incomplete observations recorded, for example no temperature, blood pressure or pulse.
- Significant delay of 5 days in treating hypercalcaemia present on admission
- Inappropriate fluids given.
- Medical documentation limited.
- Did not recognise increasing confusion and hypotension as sepsis.
- Inadequate monitoring by nursing staff and miscalculation of EWS as not recognising new confusional state – recording alert when patient was unrousable.
- Poor blood glucose monitoring – insulin not given as patient ‘refused as not eating’.
- Family not informed of patient transfer to RSH so tried to visit at PRH.
- Poor documentation around decision making and transfer of patients across hospital sites.

4.4 Care During a Procedure Rating:

There were 24 SJRs completed during the year which included a rating for care during a procedure. Of these, the care in 19 cases was rated as ‘Good’ or ‘Excellent’. Examples of findings to justify these ratings relate to:

- Clear post-operative plans
- Good intra and post-operative care
- Excellent management pre and post biopsy with good documentation of procedure
- Good documentation of cannula attempts which were difficult and stopped at patient request

One SJR completed during 2022-23 rated care during a procedure as poor. The aspects of care that were felt to be poor related to the completion of Local Safety Standards for Invasive Procedures (LocSIPPS) for intubation, percutaneous tracheostomy, and central venous catheter insertion. However, no problems in care were felt to have caused harm and overall, the death was not felt to have been preventable.

4.5 End-of-Life Care Rating:

Over 52% of cases reviewed during 2022-23 received care that the reviewers rated as 'Excellent' or 'Good'. Elements of care described which provided justification for these ratings relate to:

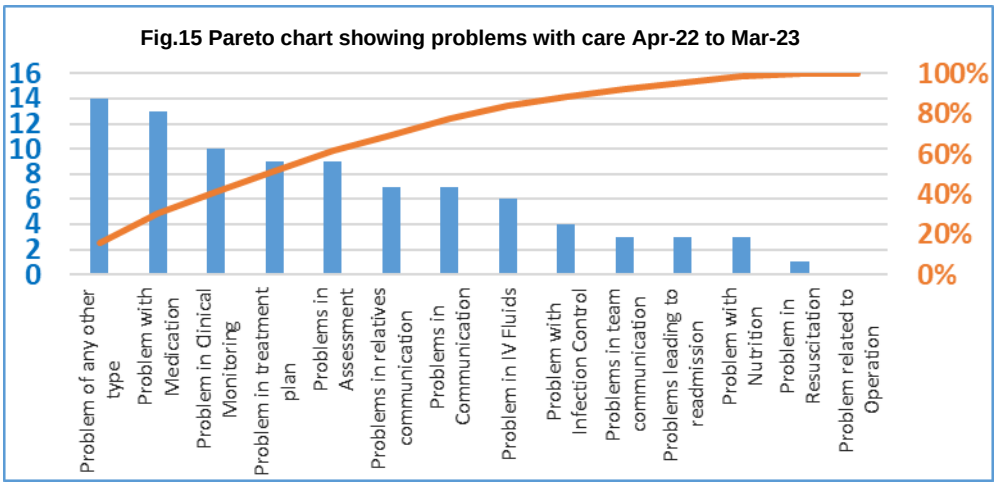
- Several examples of clear and open communication with family regarding end-of-life care and decision to withdrawal treatment
- Appropriate use of Swan care plan
- ReSPECT forms completed and plan for example regarding CPR adhered to
- Anticipatory medication prescribed and administered was noted in several of the cases
- Family present at end-of-life / compassionate visiting facilitated
- Early recognition of deterioration and initiation of end-of-life plan
- Fast track discharges planned
- Involvement of end-of-life / palliative care team
- Excellent nursing and medical care
- Joint review by specialist nurse and palliative care consultant

Examples of 'Poor' or 'Very Poor' care during the end-of-life phase relate to:

- Delay with prescribing and administering anticipatory medication
- Poor documentation of prognosis and clinical condition despite recognition of this and no end-of-life discussion with patient or relatives. Family contacted but patient died with medical and nursing staff present.
- 'Non-existent' formal end-of-life care, dying not identified, escalation decisions were either left with the patient to decide or avoided altogether (….) for a whole week.

4.6 Problems in Care identified within completed SJRs 2022-23:

SJR reviewers are invited to identify problems in care according to the categories as per Figure 15 below, which is also seen within the dashboard at Appendix C. 'Problems in care' were identified in 44 completed SJRs. Figure 14 reflects the number of times each problem was identified/ Cases may have more than 1 problem identified.



Further analysis has been undertaken by the Learning from Deaths team to understand greater detail about the specific issues within each 'problem with care' category:

a. 'Problem of any other type' - there were 14 cases where 'problems of any other type' were identified. Of these, 8 cases were recorded as having ambulance offload delay.

   Other problems noted within this category include:

   - Continuity of care issues
   - Transfer issues including delay in transfer to respiratory ward following decision for AIRVO, transfer between sites without clear clinical grounds being established and appropriate communication, transfer from ITU to surgical ward despite main concern relating to cardiology
   - End-of-life care planning / ReSPECT
   - Recognition of very sick / deteriorating patient
   - Delay in obtaining ITU opinion
   - Lack of Consultant involvement in diagnosis / decision making
   - Documentation issues
   - Medication issues
   - Clinical monitoring issues

b. 'Problem with medication' – there were 13 SJRs where a problem with medication was identified, which can be further categorised to include:

   - Administration errors
   - Prescribing errors
   - Problem with the administration or prescribing of anticipatory medication
   - Problems with IV fluids and cannulation, including delay in medication due to inability to cannulate
   - There was one case where a problem with medication had been identified but it difficult to identify what specific problem the reviewer had identified

c. 'Problem in clinical monitoring' – there were 10 'problems in clinical monitoring' identified, which can be further categorised to include:

- Delays in assessment
- Omission of observations
- Problem with pressure care assessment
- IV fluid balance concerns
- Blood monitoring problems
- Blood glucose monitoring issues
- Concern regarding recognition of sepsis
- Blood gas monitoring concern
- Monitoring of confusion

d. 'Problem in treatment plan' – there were 9 problems in treatment plan identified, which can be further categorised to include:

- Diabetic Ketoacidosis protocol issues
- Escalation concerns
- Delay in seeking specialty review
- Management of hyperkalaemia
- Management of hypercalcaemia
- Documentation issues
- End-of-life care concern

4.7 Hogan score of preventability

An SJR that identifies preventability greater than 50:50 requires further investigation. The outcome scores provided in the completed SJRs is shown at Figure 16. There were no SJRs completed within 2022-23, where preventability was rated as greater than 50:50.

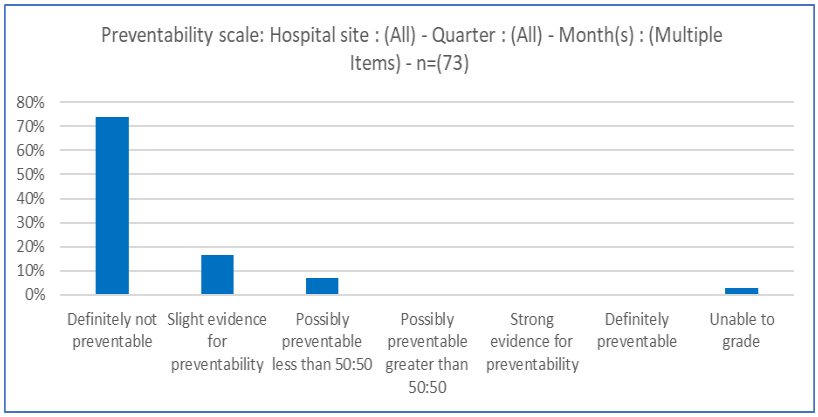


Fig.16 Hogan scores

4.8 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) score:

NCEPOD includes useful descriptors about organisational as well as clinical learning. During 2022-23, NCEPOD ratings were awarded as shown at Figure 17. There were 2 cases where the NCEPOD rating was 'less than satisfactory and 9 cases where the reviewer judged that there was room for improvement in organisational care.

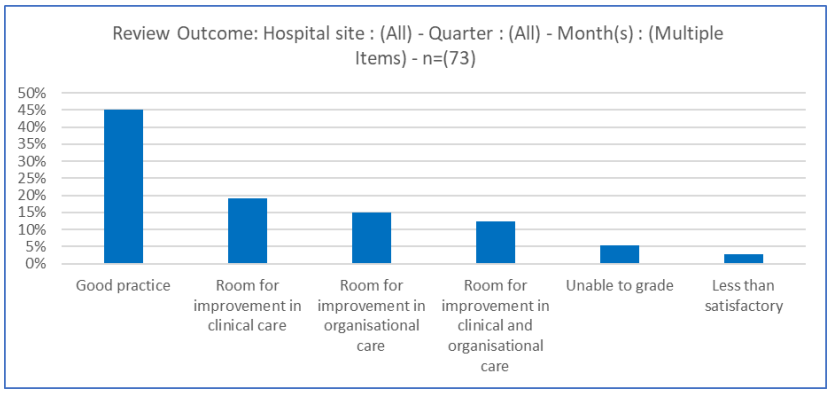


Fig. 17 NCEPOD ratings

4.9 Positive and negative lessons learned identified within the SJRPlus:

One of the key elements within the SJRPlus is an ability to identify lessons so that these can lead to change and improve care. SJRPlus has been designed to encourage the reviewer to highlight positive lessons for affirmation learning and consolidation of good practice as well as identify care delivery that has not met expected standards (Better Tomorrow Leads NHSE).

Within all the completed SJRs during 2022-23, 58 identified lessons to be learned, 54.8% of these were positive lessons and 71.2% were negative. Examples of comments are shown in table 1 below.

Table 1: Examples of positive and negative learning identified in SJRs 2022-23

Positive Lessons	Negative Lessons
Timely escalation and review of deteriorating patient	Lack of documentation from ED medical team
Good holistic care evident	Diagnosis of DKA made without examining patient
Nursing staff on AMU recognised that despite relatively stable EWS, patient looked very unwell and escalated to medical registrar	Lack of MCA/Best Interests and DoLs documentation
Good reviews and escalation, communicated well with family	Delay in administering anticipatory medications
On call registrars in medicine and ICU very thorough, compassionate, and sensible	Unable to offload COVID positive patient from ambulance due to lack of capacity in ED and wards
Good MDT care and review	Patient required ‘red resus’ for COVID pathway, no staff available so red resus closed
Good involvement with family	IV fluid prescription did not follow IV fluid policy for maintenance fluids. No evidence of fluid balance charting
Medical team recognised palliative nature early on	Recognition by acute staff that haematology patients are very vulnerable and should be prioritised for assessment
Excellent co-ordinated care between medical team/gastros/surgeons	Poor escalation for medical review
Good initial assessment and treatment of sepsis	Observations not appropriately recorded
Good documentation of ReSPECT form and capacity assessment	Delay in discharge despite being medically fit – lack of social care in community
Good support from the MDT – diabetes, respiratory and haematology teams	Delay in transferring to respiratory ward for AIRVO following decision being made
Excellent documentation	Importance of ensuring all prescribed medication is given or escalated to medical team if unable to administer
Good balance between intervention versus risk and quality of life	Lack of documentation around risks and benefits of warfarin

4.10 Concerns relating to care identified through SJRPlus:

Clinicians who undertake SJRs are required to complete an 'SJR datix' for all cases where ratings awarded meet certain criteria as per the Trust Learning from Deaths policy, including 'poor' / 'very poor' care ratings, greater than 50:50 evidence if preventability, NCEPOD rating 'less than satisfactory'. This aims to ensure that cases where potential acts or omissions in care may have resulted in serious harm and potentially avoidable death, which have not already been referred through Trust Governance processes for investigation, are flagged for appropriate muti-disciplinary review and consideration for potential presentation at the Trust Review Actions and Learning from Incidents Group (RALIG) if appropriate.

During 2022-23, this process has proved challenging, and to date the Learning from Deaths team are unable to provide assurance that every SJR completed which meets the criteria for a datix is being flagged in a timely manner through the datix system for further review. If the datix is not completed at the time of SJR completion by the SJR reviewer, it is challenging to retrospectively identify relevant cases. This puts the organisation at potential risk of not recognising a case where potential failings in care may have led to serious harm and therefore maximise learning to improve care and reduce preventable deaths. This could also result in a failure to accurately report appropriately within the current Serious Incident Framework which will potentially increase the risk of reputational damage.

Actions taken to mitigate this are:

- 'SJR datix' has been replaced with use of the incident reporting datix when the criteria have been met. As such cases are now being tracked through the Trust Rapid Review forum.
- In collaboration with NHSE, the Learning from Deaths team are developing a report which, when live can be run to quickly identify SJRs that meet the criteria. Prompt referral therefore refer these appropriately to the divisional Quality Governance Teams for further action.
- Weekly monitoring of relevant cases has been introduced to handover meetings between the Learning from Deaths team and the divisional Quality Governance teams.

4.11 Turning learning identified through SJRPlus into improvement:

The Learning from Deaths team acknowledge that there is still work to do to utilise the wealth of information that is now available through the use of the SJRPlus tool, including the vast array of free text comments, examples of which have been provided in the sections above. The team are working in collaboration with the Trust Patient Safety Specialist and the Divisional Quality Governance teams to plan how information from all sources including the Trust Learning from Deaths processes will be utilised following the introduction of the Patient Safety Incident Response Framework (PSIRF) to positively impact quality improvement initiatives within the Trust. The recently expanded Learning from Deaths team are also working to refine how the data is interpreted and utilised to disseminate learning both at divisional level as well as up to the Board of Directors. It is therefore anticipated that this report will be further developed to reflect these improvements during 2023/2024.

5.0 Learning identified through the wider Learning from Deaths processes in the Trust

5.1 Themes noted through Mortality Triangulation Group (MTG) within Q4 2022-23 include:

- Ambulance offload delays and delays in ambulance pick up of the patient as noted by through Medical Examiner Scrutiny continue to be recognised as key themes during the quarter. Individual cases are referred to the West Midlands Ambulance Service Patient Safety Lead for review as appropriate.
- Discharge issues noted through Medical Examiner Scrutiny. Within Q4, the MTG continues to identify cases where the patient has been deemed medically fit / optimised for discharge (MFFD / MOFD) but then deteriorates and dies. In particular, MTG is monitoring patients who have been deemed MFFD / MOFD but then deteriorate and a hospital acquired infection is noted on the death certificate. Relevant cases are referred to the division for identification of learning / SJR.
- Death following recent admission and discharge - cases where the patient has been readmitted following a recent discharge and then dies.
- End-of-Life care – key themes identified relate to issues with pain relief / anticipatory medications, delay in commencing end-of-life care / recognition of deterioration, communications issues and ReSPECT form issues.
- Various concerns relating to medication issues have been identified during the quarter and will be monitored through MTG. Concerns relating to medications are referred to the Trust Medicines Safety Officer for review and liaise across the Trust and / or Integrated Care System (ICS) as required. Specific concerns raised during this quarter include concerns relating to Apixaban prescription (5 cases – including community and hospital), missed antibiotics over the weekend, Tazocin prescribing for penicillin allergic patient (3 cases identified through MTG during quarter), delay in changing medication to appropriate alternative when patient unable to tolerate orally, incorrect Tinzaparin dose for patient weight, Parkinson's medication delayed, patients being cared for in the emergency department corridor not receiving their 'normal' medications.
- Documentation issues including 2 cases where there has been no evidence of regular medical review in the days prior to death, errors in noting including documentation of liver instead of lung cancer, ME informed of a conversation about EoLC that a bereaved family had had with the medical team but no evidence of this discussion in notes.
- Spinal anaesthetic problems – since December 2022, 3 patients who have undergone surgery for a fractured neck of femur under spinal (on different sites) became acutely unwell shortly after surgery. These cases are currently undergoing an anaesthetic review to identify if there is any specific learning that may have impacted the outcome for these patients. No immediate concerns have been raised although the review will be presented to the Trust Learning from Deaths group on conclusion.

5.2 Learning from Excellence

To celebrate examples of good practice especially where positive feedback has been received from the family, 'You are appreciated' cards are sent from the Learning from Deaths team / Medical Examiner team to individual clinicians or clinical teams. During Q4 2022-23, 12 'You are appreciated' cards have been shared appropriately. In addition, two junior doctors were specifically nominated by one of the senior medical Consultants who, after reviewing their medical records wanted both of these clinicians to be recognised for the high standard of their documentation.

5.3 Specific positive and negative learning from deaths identified by the Medicine and Emergency care Division during Q4 2022-23 is shown at table 2.

Table 2: Examples of positive and negative learning identified within MEC 2022-23	
Positive	**Negative**
Good clear assessments	Overcrowding in the emergency department
Clear documentation around escalation and review of patient	Lack of capacity
Good communication with family	Poor use of food charts
Evidence of good holistic care	Need for earlier referral to Speech and Language Therapy team (SALT)
	Availability of specialised respiratory beds
	Senior support for juniors at PRH
	Poorly signed and timed medical entries in notes
	Need to consider earlier CT Pulmonary Angiogram scan (CTPA) in view of high D dimer
	Availability of out of hours echocardiography
	Delay in transporting blood samples to laboratory

5.4 ReSPECT forms

In recognition of the number of concerns raised across the Trust through the Learning from Deaths agenda, a task and finish group has been established within Q4 2022-23, including representation from colleagues from the ICS. This group aims to review some of the challenges around accurate and timely completion and appropriate use of the ReSPECT form, both within the acute Trust but also across the ICS, to include training requirements for groups of staff.

6.0 Deaths of patients with a confirmed Learning Disability

6.1 In Q4 2022-23 there were 3 patients with confirmed learning disabilities, who died in the Trust either as an inpatient or in the emergency department. These cases have been reported to the service improvement programme for people with a learning disability and autistic people (LeDeR). SJRs are currently in progress for these patients.

6.2 Overall, there have been 12 deaths of patients who have died in the Trust with a confirmed learning disability during 2022-23 who have been reported to LeDeR. SJRs have been completed for 8 of these patients and forwarded to the ICS for inclusion within the LeDeR review. Unfortunately, one SJR for a patient with a learning disability who died within Q1 2022-23 remains outstanding – the case was unfortunately not flagged by the ME for SJR but was later identified through a validation exercise undertaken during December 2022 and subsequently handed over to the division for completion. To mitigate the risk of such a delay in the future, a programme of regular validation between ME data and the Trust Data Warehouse has been introduced within the Learning from Deaths team.

6.3 There has been some delay experienced within the organisation when sharing completed SJRs with the LeDeR reviewers from the ICS, specifically since December 2022. This has been due to a technical issue following migration to the new version of the online SJRPlus platform. This has now been resolved, however due to the general delay in SJR completion across the Trust, it has proved challenging to facilitate timely completion of relevant SJRs which in turn, is having a negative impact.

6.4 There is a risk that if SJRs are not completed in a timely manner within the Trust for patients who die with a learning disability, they cannot be forwarded for inclusion within the external LeDeR review and the Trust will not be compliant with the NQB 2017 Learning from Deaths National Guidance. A failure to complete SJRs for this group of patients will potentially present missed opportunities for both positive and negative learning being identified by the Trust.

6.5 Research has shown that people with a learning disability and autism die earlier in their lives and do not receive the same quality of care as people who do not have a learning disability or autism. It is vital that the Trust prioritises case record review for patients who die whilst receiving care within the organisation to ensure that learning opportunities are maximised and opportunities for quality improvement initiatives for this group of vulnerable patients are not lost.

6.6 Learning identified within the 8 SJRs completed for patients with a learning disability within 2022-23 is shown at table 3.

Table 3: Examples of learning identified in SJRs completed for patients who have a learning disability 2022-23

Positive	Negative
Advanced care plan for young people in place and available via SEMA	Remained in the emergency department for 40 hours before transfer to ward
Good balance between intervention versus risk and quality of life	No evidence of referral to learning disability services
ReSPECT form bought in from community	No Mental Capacity Act / Best Interests form done for completion of ReSPECT
Care plan from community referred to in assessments	IV fluid prescription did not follow Trust policy on the emergency department prescription or drug chart
Family allowed to remain at bedside as deteriorated	Seen by doctor within 30 minutes or arrival, treatment prescribed 90 minutes later, outside sepsis window
Good evidence of explanation of plans of care and patient choice	Fluid balance not completed properly
Mental capacity assessments undertaken	
Good holistic care and assessment for this vulnerable patient and family	
Patient passport available for staff	
Patient had carers with him throughout stay in ED and on AMU, who delivered most of personal care with nursing staff assisting	
Regular medical reviews and family updates	
Very good, individualised care and person-centred decision making	
Good referrals to specialists including learning disability team and dieticians	

7.0 Deaths of Patients with a Serious Mental Health Condition:

7.1 In Q4 2022-23, there have been 3 deaths identified of patients with a serious mental health illness. Overall, during the year, there have been a total of 11 deaths identified of patients with a significant mental health illness either an inpatient or in the emergency department. At the time of writing this report, 7 SJRs for these patients remain outstanding.

7.2 A Mental Health Specialist Nurse has now been recruited in the Trust and, following appropriate training, is now supporting completion of SJRs, providing a specialist

review of care for patients who die with a serious mental health illness whilst under our care as an inpatient or in the emergency department. This supports the primary review of care undertaken by the relevant clinical teams.

7.3 The Trust must prioritise the completion of SJRs for all patients who die with a serious mental health condition otherwise it is at risk of being non-compliant with the NQB (2017) Learning from Deaths National Guidance. As a result, there will be missed opportunities to identify both positive and negative learning and maximise opportunities for quality improvement initiatives for this group of vulnerable patients.

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'.

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 There have been no maternal deaths in the Trust in Q4 2022-23 and none during the year 2022-23

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

Table 4: Perinatal mortality 2022-23

Term	Definition	SaTH Q4 data	2022-23 Annual figures
Stillbirths	Baby delivered from 24+0 weeks gestation showing no signs of life	2	13
Early neonatal deaths	Death of a live born baby (20 weeks gestation or later) occurring before 7 days of life	1	10
Late neonatal deaths	Death of a live born baby occurring between 7 and 28 completed days after birth	1	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	4	6

8.5 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. The unit where the baby died is responsible for the reporting to MBRRACE and leading the PMRT.

8.6 During 2022-23, 32 perinatal mortality reviews have been undertaken in the Trust. Two HSIB reports are awaited from intrapartum stillbirths reported in September and

November 2022, although initial indications suggest that there are no safety recommendations from these investigations.

8.7 During 2022-23, there have been a total of 4 serious incidents relating to perinatal mortality which were reported to the Strategic Executive Information System (StEIS) during. None of these have been within Q4 2022-23.

9.0 Paediatrics

9.1 During 2022-23, there have been 13 paediatric deaths managed by the Trust Medical Service, including 2 neonatal deaths. Within Q4 2022-23, there have been 3 inpatient / ED deaths of children under the age of 18.

9.2 One serious incident relating to a child death was reported by the Trust to StEIS during Q4 2022-23. This investigation remains open and specifically aims to address concerns relating to the recognition and escalation of deterioration in paediatric patients.

9.3 One serious incident relating to the death of a child was concluded and presented to the Trust Review Actions and Learning from Incidents Group (RALIG), chaired by the Executive Medical Director, the learning of which including recommendations for improvements in care, is shared in accordance section 10.2.

9.4 A thematic review investigating the deaths of 3 further children was also presented to RALIG in Q4 2022-23, the learning of which, including recommendations for improvements in care, is also shared in accordance with section 10.2

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. The methodology used to investigate potentially avoidable deaths in the Trust is the Serious Incident Framework.

10.2 On completion of an 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 following the serious incident investigation 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 learning identified within these investigations is provided in the monthly Incident Overview Report presented to the Quality and Safety Assurance Committee and the Quarterly Learning from Incidents Report presented to the Quality and Operational Committee.

10.3 There are currently 12 serious incident investigations which have been concluded and presented to RALIG, where the outcome regarding preventability remains outstanding.

10.4 In Q4 2022-23, there have been 14 serious incidents relating to patients who have died, reported externally to the Strategic Executive Information System (StEIS). Of these, 13 of these investigations remain open.

10.5 Following serious incident investigation, one paediatric death within the Trust presented to RALIG in Q4 2022-23 was deemed more likely than not to have been due to problems in healthcare and therefore to have been potentially avoidable. Learning and recommendations from serious incidents is shared as described at section 10.2.

11.0 Risk register

11.1 There is one risk that remains on the Trust Risk Register relating to recruitment within the Learning from Deaths. for 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.

11.2 Appropriate office space accommodation has not yet been identified to house the expanded Learning from Deaths team. As a completely new team within the organisation, the lack of appropriate office space is negatively impacting on the ability to establish team dynamics, define new roles and responsibilities and support the development of expertise and knowledge among the new team members which is essential to progress the wider learning from deaths agenda.

Roger Slater, Trust Senior Clinical Lead for Learning from Deaths
Fiona McAree, Head of Learning from Deaths and Clinical Standards
May 2023

APPENDIX A: Medical Examiner and Bereavement Service Q4 / Annual Summary 2022/23 Report

Please see attached

Appendix B: Glossary

SHMI	Summary Hospital-level Mortality Indicator SHMI data includes deaths in hospital and those which occur within 30 days of discharge. Excludes Covid-19 patients
SHMI Observed (Obs) deaths	Number of actual deaths in hospital or within 30 days of discharge
SHMI Expected (Exp) deaths	Number of expected deaths in hospital or within 30 days of discharge according to the SHMI model
Obs vs Exp 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 and observed deaths may be impacted by quality of care provided.
CHKS	Provider of healthcare intelligence and quality improvement services, used to provide analysis of mortality metrics within SaTH and support internal performance monitoring.
Charlston Comorbidity Score	Predicts the 10-year mortality in patients with multiple comorbidities.
RAMI model	Risk Adjusted Mortality Index. Excludes Covid-19 patients
SJR	Structured Judgement Review
SJRPlus	The online mortality review tool adopted by SaTH and developed by NHSE
SJR Datix Criteria	• Death where the patient was not expected to die • Any care rating of poor / very poor care • Hogan score where the element of preventability was rated greater than 50:50 or above • Any problem in care category where harm was identified • NCEPOD rating of less than satisfactory

Appendix C: Learning from Deaths Dashboard Overview Summary

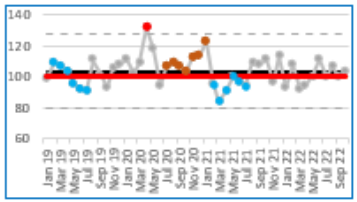
Shrewsbury & Telford NHS Trust

Context

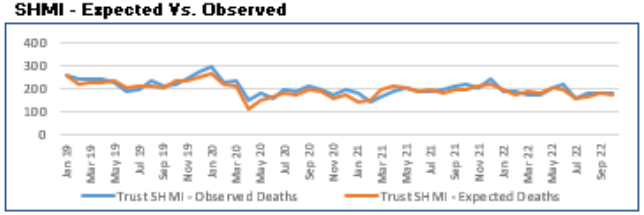
Detail

SHMI

Latest month	Oct 22
SHMI	102.84
SHMI is expected range	
Observed deaths	184
Expected deaths	179



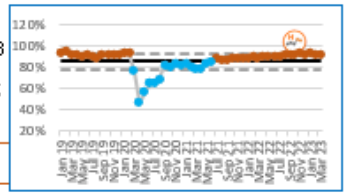
SHMI - Expected Vs. Observed



Hospital Occupancy

Latest month	Mar 23
%	90.8%

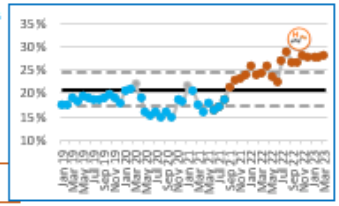
Significant deterioration



% Patients with LoS > 14 days

Latest month	Mar 23
%	28.1%

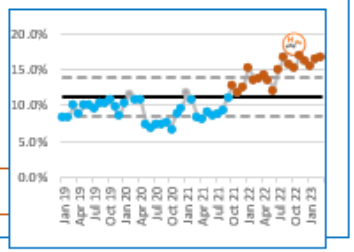
Significant deterioration



% Patients with LoS > 21 days

Latest month	Mar 23
%	16.7%

Significant deterioration



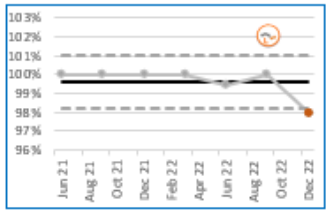
Scrutiny to SJR

Detail

No. deaths scrutinised by ME - Q5h

Latest month	Dec 22
%	98.0%
Number	621

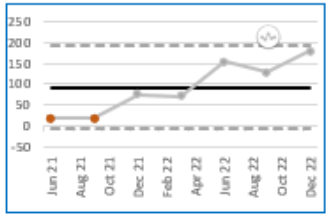
No significant change



No. MCCDs not completed within 3 calendar days of death - Q16

Latest month	Dec 22
Number	180

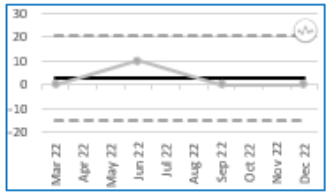
No significant change



No. Patient Safety Incidents notified by medical examiner office as a result of scrutiny - Q23

Latest month	Dec 22
Number	0

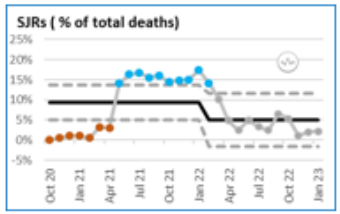
No significant change



SJRs (% of total deaths)

Latest month	Jan 23
%	2.1%

No significant change



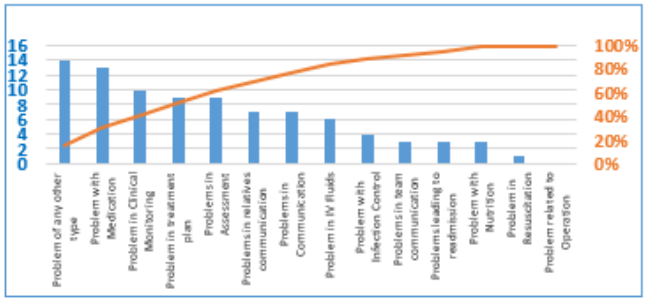
Care

Detail

Good care identified

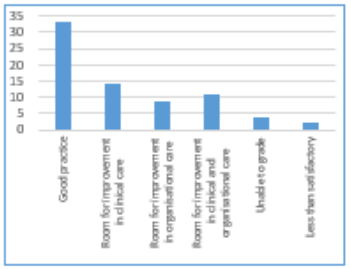
In 33 out of 73 cases (45%) good care was identified

Problems with care Apr-22 to Mar-23



NCEPOD definitions Apr-22 to Mar-23

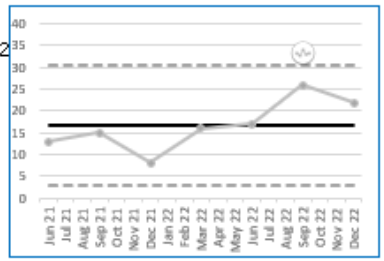
Good practice	33
Room for improvement in clinical care	14
Room for improvement in organisational care	9
Room for improvement in clinical and	11
Unable to grade	4
Less than satisfactory	2



Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers – Q20a

Latest month	Dec 22
Number	22

No significant change



Appendix D: Causes of Death identified within completed SJRs 2022-23

SJR	MCCD Part I(a)	MCCD Part I(b)	MCCD Part I(c)	MCCD Part II
1	Congestive Cardiac failure, 2			Type II Diabetes Mellitus
2	Bronchopneumonia,			Downs Syndrome, Epilepsy, Dementia
3	Pneumonia			CKD
4	Acute pancreatitis			Ischaemic heart disease, Crohn's disease
5	Pneumonia,			Chronic renal failure, ischaemic heart disease, frailty of old age
6	Bronchopneumonia			Cerebral Palsy/Epilepsy
7	Brain Cancer			
8	Bronchopneumonia,	Frailty		Common bile ducts
9	Cerebrovascular disease plus COVID positive			Type 2 Diabetic Heart Failure
10	Acute exacerbation COPD			Metastatic carcinoma of pancreas
11	Non- Hodgkin’s lymphoma			
12	Intestinal ischaemia			
13	Spontaneous intracranial bleed			
14	Glioblastoma Multifocal			
15	Status epilepsy	epileptic encephalopathy		Learning disability
16	Urosepsis			frailty, covid-19
17	Bronchopneumonia	Advanced Parkinson's disease		COPD & AF
18	Mantel Cell Lymphoma			
19	Spontaneous Bowel Obstruction			
20	End stage renal failure	Diabetes Mellitus		
21	Aspiration Pneumonia	Frailty	Schizophrenia	Coronavirus Infection
22	Uro-sepsis			frailty, cardiac failure
23	Multi Organ failure	Anastomotic leak (ileo-colostomy)	Elective Right Hemicolectomy Caecal Adenocarcinoma	Atrial Fibrillation, Hypertension
24	Pneumonia	Myelodysplasia		Ischaemic heart disease
25	Pulmonary Oedema	Myocardial Infarction	Hospital acquired pneumonia	

Appendix D: Causes of Death identified within completed SJRs 2022-23

SJR	MCCD Part I(a)	MCCD Part I(b)	MCCD Part I(c)	MCCD Part II
26	Metastatic Gallbladder Cancer			Hypertension and Hyperthyroidism
27	Acute Renal Failure	Chronic Renal Failure		Diabetes Mellitus
28	Bronchopneumonia & Heart failure	Myocardial infarction		Type 2 Diabetes
29	Left MCA stroke, lung cancer			
30	Pulmonary Renal Syndrome	Vasculitis		Hypertension
31	Acute kidney injury (non-traumatic)	sepsis	covid pneumonitis	diabetes mellitus, hypertension
32	Metastatic colon cancer			
33	Heart Failure			COPD, Asthma
34	Lymphoma			
35	Klebsiella Urosepsis			Advanced Dementia and Bipolar Disorder
36	Necrotising Fasciitis	Transitional Cell carcinoma of bladder		IDDM
37	Metastatic oesophageal cancer			
38	Abdo sepsis	pancreatitis		diabetes mellitus
39	CCF			COPD
40	Bronchopneumonia			Frailty of old age
41	Sepsis	Bronchopneumonia		Ischaemic Heart Disease, H. Hernia & Oesophagoduodenal Stricture
42	Pulmonary embolism			
43	Metastatic Breast Cancer			
44	Bronchopneumonia secondary to Covid pneumonitis			
45	Bronchopneumonia			
46	Aspiration pneumonia	Downs syndrome		Dementia
47	Spontaneous oesophageal perforation			COPD, CVA
48	Colonic cancer			metastatic prostate cancer
49	High grade lymphoma			
50	Myocardial Infarction due to Diabetes Mellitis			Covid infection
51	Bronchopneumonia	Ependymoma		
52	Empyema			

Appendix D: Causes of Death identified within completed SJRs 2022-23

SJR	MCCD Part I(a)	MCCD Part I(b)	MCCD Part I(c)	MCCD Part II
53	Bronchopneumonia	COVID pneumonitis		Idiopathic Pulmonary Fibrosis
54	Covid pneumonitis			Chronic lymphocytic leukaemia
55	Bronchopneumonia	COPD and Obesity hypoventilation syndrome		Chronic Kidney Disease
56	Sepsis	Cellulitis		Acute Renal Failure secondary to Sepsis
57	Acute sub-dural haemorrhage	RA and frailty		
58	Chest infection			viral gastroenteritis, frailty old age
59	Urosepsis	Bladder cancer and non-small cell cancer of the lung		
60	Multiple organ failure	CCF		vascular dementia, frailty of old age, CKD, pneumonia
61	Bronchopneumonia, metastatic breast cancer, severe aortic stenosis, acute on chronic kidney disease			
62	Acute Renal Failure	Biliary Sepsis		Frailty of old age
63	PE			Asthma, Hypertension, Diabetes
64	Bronchopneumonia			covid-19 frailty
65	Pneumonia	chronic obstructive pulmonary disease		ischaemic heart disease. frailty of old age
66	Hospital Acquired Pneumonia			
67	Exacerbation of chronic obstructive pulmonary disease.			Covid-19 infection, hypertension
68	Multi organ failure	Covid 19 pneumonitis and Klebsiella Septicaemia		Downs syndrome with dementia
69	Decompensated Congestive Cardiac Failure			Chronic Kidney Disease, Ischaemic Heart Disease, Frailty of Old Age, Peptic Ulcer Disease
70	Bronchopneumonia, infective exacerbation chronic obstructive pulmonary disease			Cardiovascular disease, hypertension
71	CCF	AS		Parkinson's Disease, frailty
72	Non infective exacerbation of COPD			
73	Septicaemia	Covid-19		Metastatic osteosarcoma
74	Urinary sepsis			Advance dementia and bipolar disorder
75	Covid pneumonitis			frailty
76	Multiorgan failure	Bronchopneumonia	Lung Cancer	COPD
77	Spontaneous Intracerebral Haemorrhage			