The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting
12th October 2023

Agenda item	125/23			
Report Title	How We Learn from Deaths and Medical Examiner / Bereavement Service Quarter 1 2023-24 Board Summary Assurance Report			
Executive Lead	Dr John Jones Executive Medical Director			
Report Authors	Dr Roger Slater, Trust Senior Clinical Learning from Deaths Lead, Fiona McAree, Head of Learning from Deaths & Clinical Standards Dr Suresh Ramadoss, Lead Medical Examiner, Lindsay Barker, Medical Examiner Service Manager,			
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	√	ID 435
Well Led	√	Our partners	√	
Consultation Communication	Trust Learning from Deaths Group, 3rd August 2023 Quality Operational Committee, 15th August 2023 Quality & Safety Assurance Committee, 27th September 2023			
Executive summary:	• 31 % of non- coronial cases did not have their of death certificate issued within 3 days and it is likely that this has been affected by industrial action and bank holidays • The medical examiner service is carrying out bereavement work while bereavement team growth awaits business planning approval. Regional funding for the ME Service is at risk if this continues • 5 deaths were noted as potentially avoidable in quarter 1 2023-24. • There is no specialist to support SJRs for patients who die with a learning disabillity or autism risking non-compliance with national guidance and less ability to learn. Options are being considered. • PMRT continues to be used to identify learnings from neonatal mortality and the invited expert review in relation to the above average mortality highlighted in MBBRACE reports is underway. • The increase in mortality in ED in quarter(q)3 2022-23 compared to q3 2021-22 was also seen comparing q4 2022-23 to q4 2021-22, however this figure has decreased comparing q1 2023-2024 with q1 2022-2023. The detail of the investigation is described in section 4.			
Recommendations for the Board:	The Board is asked to note and take assurance from the report.			
Appendix 1 – in Supplementary Information Pack	How We Learn from Deaths Q1 2023-24 Full Report including Medical Examiner and Bereavement Service Report.			

1.0 Introduction

1.1 There have been 546 inpatient and emergency department (ED) deaths recorded and managed by the Medical Examiner (ME) Service within the Trust during Q1 2023-24, a reduction of 79 deaths compared to Q4 2022-23. Following a spike in deaths within the emergency department during Q3 2022-23, a downward trend can now be noted as seen at chart 1 below. Section 4 provides further details of the ongoing review into mortality within ED.

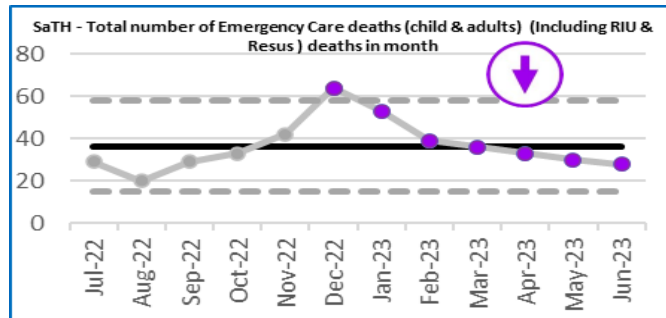

Chart.1 Deaths in the emergency department

1.2 This report is divided into 2 parts and provides a summary of key information contained within the full reports as included within the Supplementary Information Pack. Part A provides an update from the Medical Examiner and Bereavement Service and Part B, provides an update from the Learning from Deaths agenda in the Trust.

2.0 PART A: Medical Examiner and Bereavement Service key issue update

2.1 Although a slight decrease from Q4 2022-23, 98% of the deaths that occurred in Q1 2023-24 received a Medical Examiner Officer preparatory review and 99% received a Medical Examiner scrutiny. Of these 99% bereaved relatives received a telephone call from the Medical Examiner to discuss the care, treatment, and cause of death. The cases not to have received contact from the Medical Examiner were due to a combination of no next of kin available, relatives not returning our calls and one case where the police had referred the death to the coroner directly.

2.2 All deaths that are not referred to the coroner should have a Medical Certificate of Cause of Death (MCCD) issued within 3 calendar days, to enable relatives to register the death within 5 days. Our performance against this metric is reported quarterly to the National Medical Examiner/NHSE and continues to be challenged in this quarter. Of the 435 MCCDs written that had no coroner involvement, 152 of these were not completed within 3 calendar days of death, meaning 31% were not issued in accordance with this metric. This was due to the significant pressure treating clinicians are under, the extended bank holidays in April & May followed by the junior doctor strikes. These delays cause significant upset to bereaved relatives as they wait to be able to register the death and is a reputational risk for the Trust because of the impact it creates for Registration services in meeting their performance targets. Concerns with performance in this area has been escalated and discussed with the Deputy Medical Director. The Bereavement Team continue to support the clinicians to facilitate as timely completion as possible by providing a supportive structure when they attend to write the MCCD, making our office accessible and taking death certification to their clinical area if this is needed. We also ensure registration services remain appraised of the situation. An overview of performance in this

area is outlined in the full report but this issue has been consistently challenged every quarter since the withdrawal of the Covid-19 legislation.

2.3 In Q1 2023/24 there were 36 deaths where the Medical Examiner recommended an SJR, which is a reduction of 1 from the 37 that were requested in the previous quarter.

2.4 The Medical Examiner service has now received notification from the National Medical Examiner that the non-acute system will become officially statutory in April 2024, a delay of 12 months from the previously planned date of April 2023. Significant progress with the expansion of the non-acute Medical Examiner service continues to be made in Q1 2023-24. The delay to the statutory system coming into law does not alter the robust project plan that is in place to oversee the rollout of the service to our non-acute partners and work has started with two community partners with the service reviewing 16 community deaths throughout Q1. The rollout of non-acute medical examiner reviews is being progressed in a phased approach to manage the new demand. Increasing the demand of non-acute deaths will create operational challenges if recruitment to the vacant ME sessions is unsuccessful in Autumn 23, causing a delay to the schedule of the project plan.

2.5 A business case requesting the establishment of two Band 4 Bereavement Officers and a Band 5 Bereavement Supervisor to release MEO capacity has been presented to the Trusts funding approval process in April 2023. Whilst the business case has the support of the Trust's Senior Leadership Team, we are now awaiting final approval from the Innovation and Investment Committee (IIC). It is anticipated that the business case will be approved at risk so that the required development of the Bereavement Service can commence and the risk of national funding into our service of the MEOs is not withdrawn due to the conflict of roles. MEOs are funded by NHSE to provide an independent service to the ME team and should not be used to carry out the work of Trusts Bereavement Services. Should the regional and national team take the decision to pause funding of the MEOs due to their involvement in Trust bereavement work, there will be significant funding gap that the Trust will have to meet. The services reputation will also be at risk for not having the required Bereavement Service in place.

2.6 The Q4 2022-23 report highlighted a concern raised by the Reginal ME regarding direct referrals to the Coroner by the ME rather than the responsible clinician. Following this, further information was obtained at the National ME Conference in May, where the panel identified that, whilst practice may vary between different ME sites, direct referral by the ME to the Coroner **is** allowed practice. It is recognised however, that returning this practice to the clinicians would free up resource in the ME office, and in turn increase capacity to manage the additional demands of the non-acute roll out. A review of practice relating to coroner referrals will be undertaken to ensure best practice. Any changes will be communicated widely to support this process.

3.0 PART B: Learning from Deaths key issue update

3.1 The Trust's SHMI for December 2022, the latest available data at the time of writing this report, is 98.68 which is within the expected range and is favourable to the peer group. Observed deaths are largely comparable to expected deaths for the current time period. A more detailed analysis of the SHMI is contained within the full report available within the Supplementary Information Pack.

3.2 Assurance reviews have been undertaken for primary diagnosis conditions with the highest number of excess deaths within the SHMI model including anaemia, acute and

unspecified renal disease and acute cerebrovascular disease and are detailed within the full report.

3.3 Acute and unspecified kidney disease remains one of the primary diagnosis conditions with the highest excess mortality in the Trust. The Board is specifically asked to consider the strong recommendation from the renal team that SaTH commit to develop a nurse led Acute Kidney Injury (AKI) Intervention team in order to improve care received by these multi-morbid patients in an attempt to reduce AKI associated mortality and morbidity.

3.4 Since the new Learning from Deaths process was introduced early 2022, performance relating to SJR completion has been challenging due to operational challenges and resource availability within the divisions. Following the recruitment of additional SJR reviewer resource to the Corporate Learning from Deaths team, assurance can now be provided to the Board that the current target figure of 30 completed SJRs (variable dates of death) for each month (based on 2022/23 annual deaths) has been met during Q1 2023/24 as shown in chart 2 below. If this performance is sustained, sufficient data will be available in line with NHS England recommendations to appropriately identify themes and trends and inform quality improvement initiatives across the organisation. The next step for the corporate team is to identify how to manage this volume of largely 'free text' data to develop action plans and monitor / evidence improvement as a result.

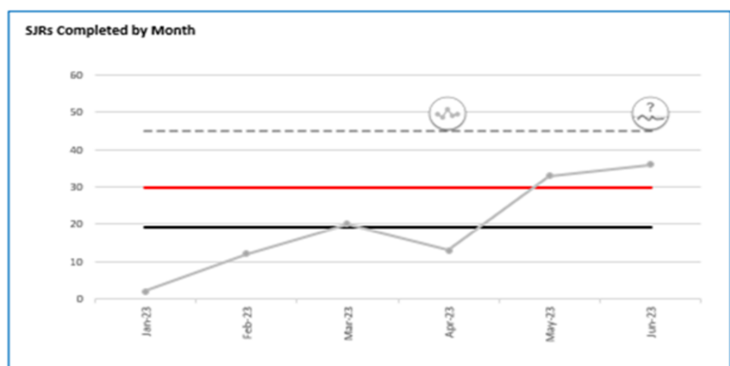

Chart.2 SJR completion by month - variable DoD

3.5 Further assurance can be provided that the timeliness of SJR completion is significantly improving within the Trust in line with the Learning from Deaths policy that SJRs should be completed within 8 weeks from the date of death. This is important to ensure learning identified through SJRs is both relevant and actionable. Assessing the timeliness of SJR completion is monitored monthly through the Learning from Deaths Dashboard using the latest month's available figure as per chart 3 below. As historically SJRs have been completed largely outside of the 8-week timeframe, inevitably previous months data is likely to show higher percentages against more recent months. The Learning from Deaths team are undertaking focused work including a review of the notes management processes to address this and it is anticipated that the Q2 2023-24 report will demonstrate even greater improvement.

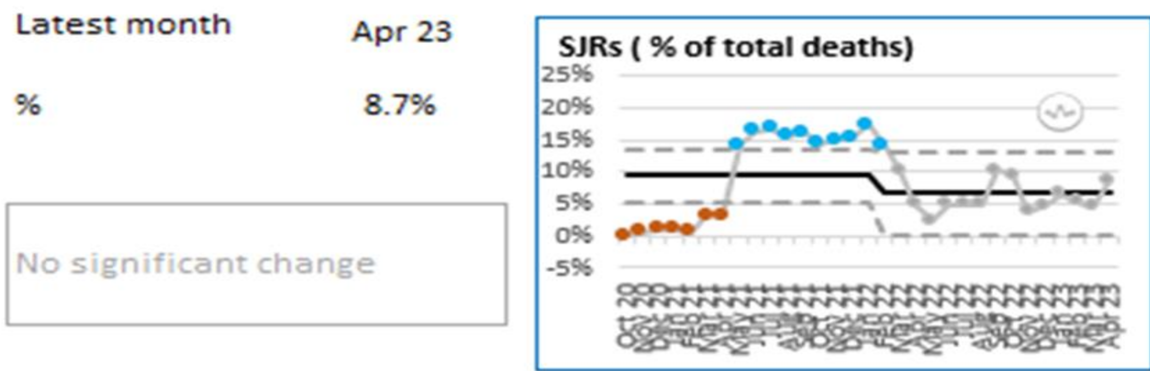

Chart.3 SJR completion by month according to the month the patient died

3.6 Over 50% of the SJRs competed during Q1 2023-24 identified an overall rating of good or excellent care being provided. Learning from excellence is celebrated through the Learning from Deaths agenda and positive feedback is sent to individual clinicians and clinical teams. In just over 10% of SJRs the care provided was rated as poor, and one of these has been reported as a serious incident. Further details and analysis including examples of learning identified are provided in the full report available in the Supplementary Information Pack. Key themes notes relate to ambulance offload delays, delays in assessment and review in the emergency department, recognition and care of the deteriorating patient, documentation issues, medication issues, communication, and end of life care.

3.7 The Board is asked to note that there are 5 deaths where the outcome relating to potential preventability has been confirmed within Q1 2023/24. The 5 cases have been presented to RALIG and thereafter judged more likely than not to have been due to problems in healthcare and therefore potentially avoidable. These serious incident investigations were reported to StEIS over an 8-month period from February to September 2022 and presented to RALIG between July 2022 and January 2023. 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 and as such, are not further detailed within this report.

3.8 In Q1 2023-24 there were 2 patients with confirmed learning disabilities reported to LeDeR, who died in the Trust, either as an inpatient or in the emergency department. At the time of writing this report, one SJR was complete and the other, is in progress. Learning identified through completed SJRs is detailed within the full report available within the Supplementary Information Pack. The Board is asked to note that currently the mandated SJRs for patients who die with a learning disability or autism, are completed by clinicians with no specialist input from the Learning Disability team to support and enhance this process. To maximise learning opportunities and to ensure that opportunities for quality improvement initiatives for this group of vulnerable patients is not lost, it is vital that the Trust prioritises resource to support appropriate specialist input with these SJRs and ensure learning is identified in a timely fashion within the Trust. Without this support, the Trust remains largely reliant on an external review process to flag key learning relevant to patients with learning disabilities and autism and as such is at risk of reputational damage and non-compliance with national guidance. This deficit in specialist resource to support

SJR review has been escalated to the Trust Learning Disability Lead, who has now retired, and the Deputy Director of Nursing. It is understood that appropriate resource for a new specialist Learning Disability and Autism Lead role within the Trust is currently under review. It is anticipated that recruitment to this post would potentially facilitate appropriate support for the SJR process for both Learning Disability and Autism, moving forwards.

3.9 In the Q4 2022/23 report, the number of outstanding mandated reviews for patients who had died with a confirmed learning disability or autism was detailed. These reviews are all now completed.

3.10 In Q1 2023-24, there was one death of a patient with a serious mental illness (SMI). At the time of writing this report, 4 mandated reviews for patients who died in Q4 2022-23 with a SMI, still remain outstanding. These are being supported by the Mental Health Clinical Nurse Specialist in the Trust.

3.11 In Q1 2023-24, there were no maternal deaths, stillbirths, early or late neonatal deaths in the Trust.

3.12 There were 3 paediatric deaths managed by the Medical Examiner Service in the Trust in Q1 2023-24. None of these deaths have a related serious incident investigation.

3.13 The Perinatal Mortality Review Tool (PMRT) continues to be used within the Trust to identify learnings from neonatal mortality, and the invited expert review in relation to the above average mortality highlighted in MBBRACE reports is underway.

3.14 There is one risk that remains on the Trust Risk Register relating to recruitment within the Corporate Learning from Deaths team. There has been turnover within the team with vacancies subject to review and there are existing office space limitations of relevance which will increase when the team are fully appointed to.

4.0 Collaborative review of deaths occurring within the Emergency Department Q3 2022-23

4.1 Following a spike in deaths within ED during Q3 2022/23, a collaborative review is in progress with senior clinicians in ED and specialty teams as previously detailed within the Q4 2022/23 report. Since the full report was written July 2023 as available within the Supplementary Information Pack, a further update can be provided.

4.2 Hypotheses presented at the start of the review:

- Due to increased length of time patients are cared for in ED, the physical location where the patients died was ED rather than the wards.
- The increased numbers were representative of the national picture.
- The increase correlates to Getting It Right First Time (GIRFT) data which suggests that a prolonged stay in ED leads to an increased mortality rate.

4.3 The cohort for deep dive review by medical teams:

- Excluded patients who had suffered an out of hospital cardiac arrest or who were brought into the ED peri-arrest.
- Was selected based on the identification of an ED Consultant by the Bereavement Team / Medical Examiner office.
- Total sample size 33 patients.

4.4 The cases were triangulated against Coroner referrals, serious incident investigations, and Datix. Triangulation against Formal Complaint data remains underway.

4.5 Since Q3 2022-23, a downward trend can be noted for the number of patients dying in the ED across both sites. Whilst there was an increase of 66 patients who died in ED during Q3 2022-23 compared to Q3 2021-22, this reduced to 58 patients in Q4 2022-23 compared to Q4 2021-22 and to 28 patients in Q1 2023-24 compared to Q1 2022-23 as seen in table 1 below. This decrease is also reflected in the percentage of deaths in ED against the total deaths occurring within SaTH for the comparable quarters.

	Q3 22/23	Q3 21/22	Q4 22/23	Q4 21/22	Q1 23/24	Q1 22/23
Total deaths in SaTH	629	557	626	496	546	519
Total deaths in ED	139	73	128	70	91	63
Difference in deaths in ED between comparative quarters	+66		+58		+28	
Overall percentage of deaths in ED in relation to total SaTH deaths	22%	13%	20%	14%	17%	12%

Table 1: Comparative quarterly figures for Mortality in ED & Total SaTH Deaths

4.6 No firm conclusions can yet be drawn to explain the spike in deaths in ED during Q3 2022-23. From the cases reviewed, no concerns in care have been identified which were thought to have impacted on the outcome, however a significant length of stay was identified for the cohort reviewed, with an average stay in the department of just over 9 hours, the longest being 41 hours and the shortest being 55 minutes. 15 patients had a length of stay over 6 hours and 9 patients had a length of stay over 12 hours. Issues around 'ownership' of patients in the ED when referred to specialty teams were identified and challenges around adherence to Internal Professional Standards relating to the time from referral to specialty teams and subsequent assessment, were highlighted.

4.7 Planned next steps:

- Review the nursing care provided for the cohort of patients.
- Compare length of stay in the ED for the comparable cohort for 2021-22.
- Maintain oversight of deaths within the ED through the weekly Mortality Triangulation Group to include patients where corridor care has been given.
- Consider the need to expand the cohort for review to include those patients who died in ED, but where the Consultant was identified by the Bereavement Team / ME office as non-ED.
- Review the process to identify the responsible Consultant by the Bereavement Team to ensure accuracy.

5.0 Learning: Action: Improvement: Turning learning into improvement

5.1 Quality improvement (QI) initiatives arising from the Learning from Deaths agenda or where triangulation with Learning from Deaths intelligence is contributing to wider QI initiatives within the Trust, are detailed within the full report as available in the Supplementary Information Pack. This includes antibiotic prescriptions for patients with antibiotic allergies, direct oral anti-coagulant use in the elderly, administration of Parkinson's medication / time critical medications, chronic pain and use of morphine, deteriorating patient and sepsis improvement work.

6.0 Recommendation(s)

The Board is asked to note the issues highlighted in this report and take assurance from the progress made within Q1 2023-24.