How we Learn from Deaths: Supplementary Information Pack

NHS The Shrewsbury and Telford Hospital NHS Trust

Board of Directors Meeting 12th October 2023

<table>
<tr><td>Agenda item</td><td colspan="4">125/23 How we Learn from Deaths SUPPLEMENTARY INFORMATION</td></tr>
<tr><td>Report Title</td><td colspan="4">How We Learn from Deaths Quarter 1 2023 2024 Full Report</td></tr>
<tr><td>Executive Lead</td><td colspan="4">Dr John Jones, Executive Medical Director</td></tr>
<tr><td>Report Authors</td><td colspan="4">Dr Roger Slater, Senior Clinical Lead for Learning from Deaths.
Fiona McAree, Head of Learning form Deaths and Clinical Standards.
Lindsay Barker, Medical Examiner and Bereavement Service Manager.
Dr Suresh Ramadoss, Lead Medical Examiner.</td></tr>
<tr><td rowspan="6"></td><td colspan="2">Link to strategic goal:</td><td colspan="2">Link to CQC domain:</td></tr>
<tr><td>Our patients and community</td><td>√</td><td>Safe</td><td>√</td></tr>
<tr><td>Our people</td><td></td><td>Effective</td><td>√</td></tr>
<tr><td>Our service delivery</td><td></td><td>Caring</td><td>√</td></tr>
<tr><td>Our partners</td><td></td><td>Responsive</td><td>√</td></tr>
<tr><td>Our governance</td><td>√</td><td>Well Led</td><td>√</td></tr>
<tr><td rowspan="3"></td><td colspan="2">Report recommendations:</td><td colspan="2">Link to BAF / risk:</td></tr>
<tr><td>For assurance</td><td>√</td><td colspan="2"></td></tr>
<tr><td>For approval</td><td></td><td colspan="2">Link to risk register: ID435</td></tr>
<tr><td>Presented to:</td><td colspan="4">Trust Learning from Deaths Group, 3rd August 2023
Quality Operational Committee 15th August 2023
Quality and Safety Assurance Committee 27th September 2023</td></tr>
<tr><td>Executive summary:</td><td colspan="4">• There have been 546 deaths (Inpatient and Emergency Department)) managed through the ME service during quarter 1 (Q1) 2023/24 compared to 519 in quarter 2 (Q2) 2022/23.
• The Trust’s latest SHMI for December 2022 was 98.68 which is within the expected range and is favourable to the peer group.
• Structured Judgement Review (SJR) completion has improved significantly over the last quarter and is now above the recommended target advised by the NHS England, Better Tomorrow Leads.
• During Q1 2023/24, 5 deaths were confirmed to have been more likely than not due to problems in healthcare following presentation at Trust Review Actions and Learning from Incidents Group (RALIG) between July 2022 and January 2023.
• There is no allocated resource currently in the Trust to support specialist input for SJRs undertaken for patients with a learning disability or autism.
• There is one open risk on the Trust Risk Register relating to recruitment.</td></tr>
<tr><td>Appendices</td><td colspan="4">A: Medical Examiner and Bereavement Service Q1 2023/24 Report
B: Overview of Learning from Deaths Dashboard
C. CHKS Peer Group
D: Glossary of terms</td></tr>
</table>

1.0 Summary of Hospital Deaths

1.1 There have been a total of 546 inpatient and emergency department (ED) deaths across the Trust during quarter 1 (Q1) 2023-24. Of these deaths, 455 occurred as an inpatient and 91 occurred within the emergency department. Charts 1,2 and 3 identify this data by month.

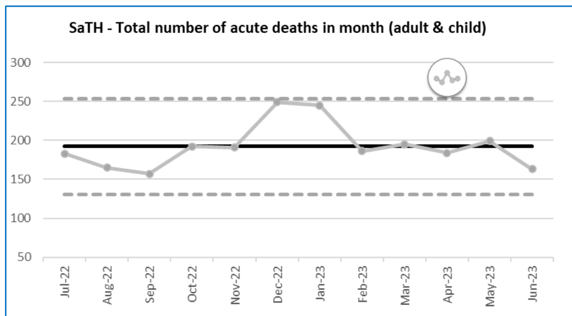


Chart. 1

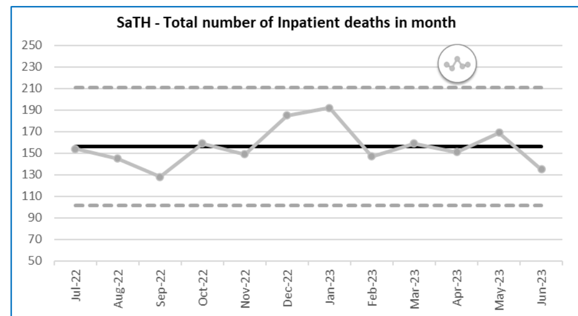


Chart. 2

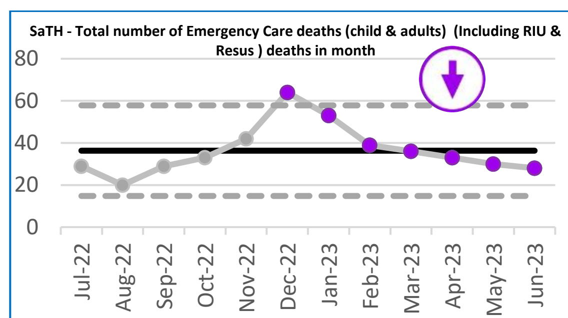


Chart. 3

1.2 Charts 4 and 5 show mortality data within the Medicine and Emergency Carer Division and Surgery and Cancer care Division.

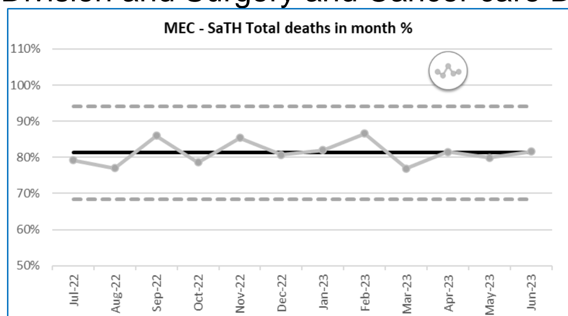


Chart. 4

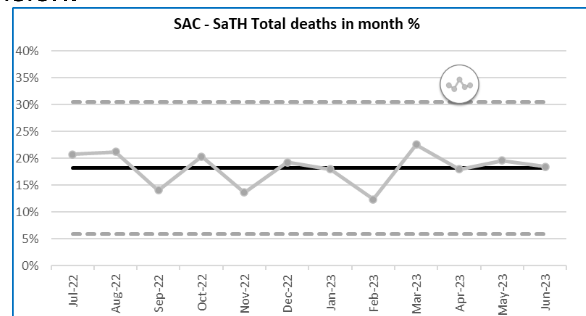


Chart. 5

2.0 Learning from Deaths Dashboard

2.1 A high level 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 December 2022, the latest available data, is 98.68 which is within expected range as shown at chart 6 and is favourable to the peer group as per chart 7 below. The CHKS peer group is detailed at Appendix C.

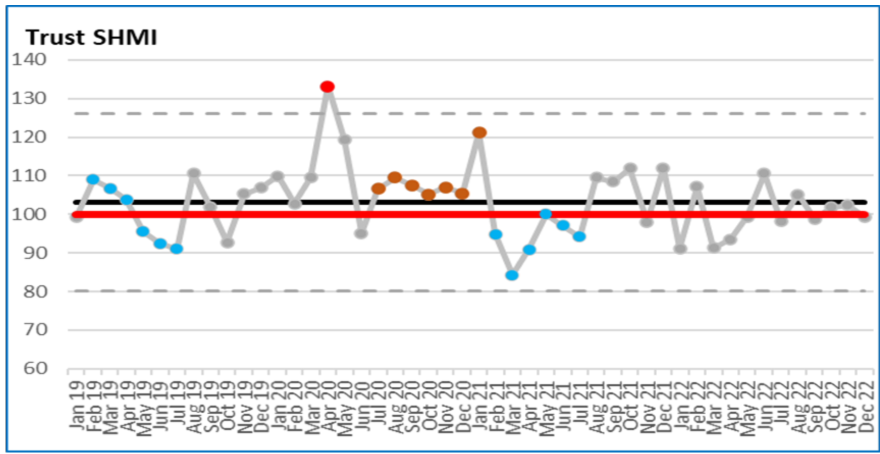


Chart. 6 Trust SHMI (Source: Learning from Deaths Dashboard)

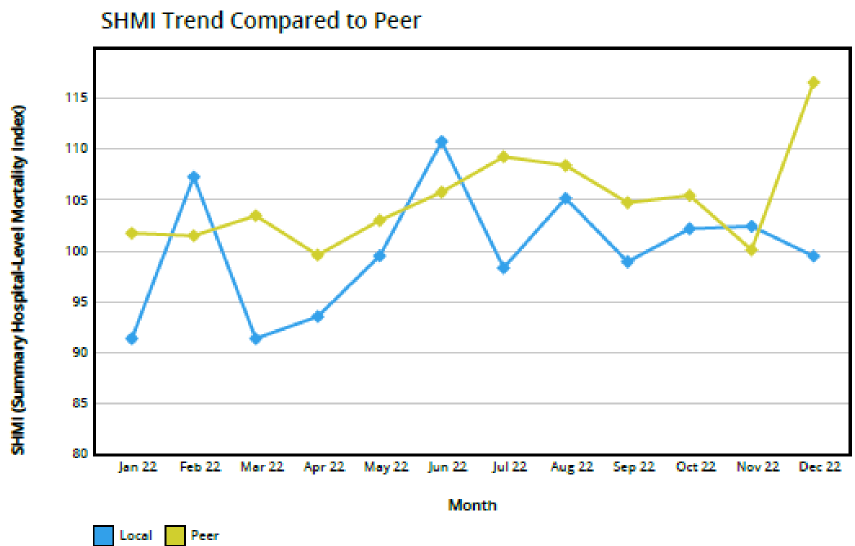


Chart. 7 Trust SHMI vs. Peer (Source CHKS)

Chart 8 shows the Trust SHMI position in relation to the peer distribution.

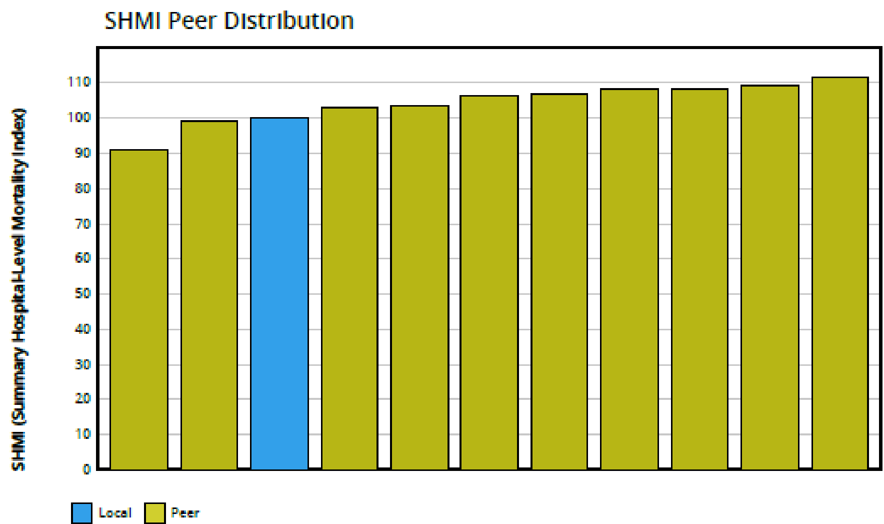


Chart. 8 SHMI Peer Distribution

2.3 The trend for observed versus expected deaths is monitored through the Learning from Deaths Dashboard and is shown at chart 9. Observed deaths are largely comparable to expected deaths for the current time period.

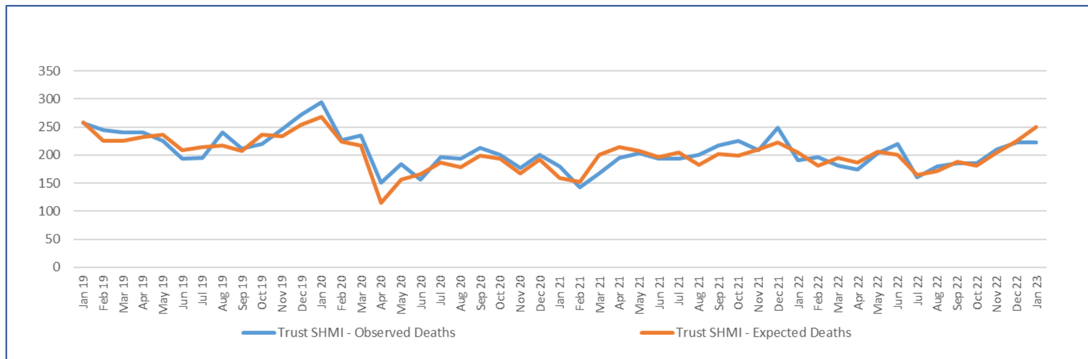


Chart. 9 Trust Obs. Vs. Exp Deaths

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 to March 2023, remains consistently below the peer group (chart 10) although to January 2023, demonstrated an increasing trend for SaTH overall and the peer (Chart 11). This has now decreased to March 2023. RAMI is generally slightly higher at PRH than RSH, and whilst it has been higher for the two months of December and January in line with the peer group over the winter months, assurance can be taken as the index remains below 100 for both hospitals (chart 12).

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.

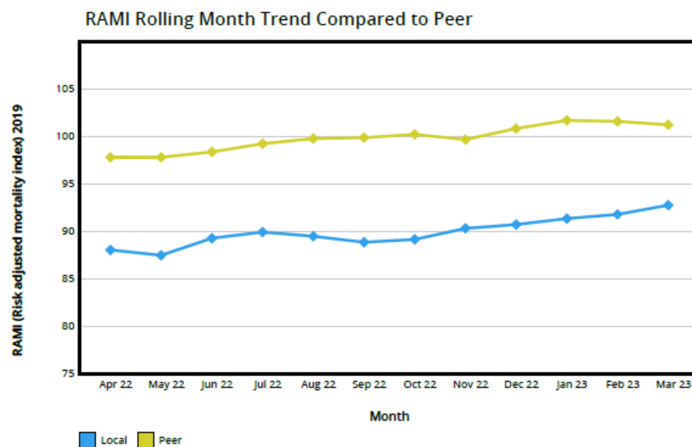


Chart. 10 RAMI Rolling Month Trend to Peer

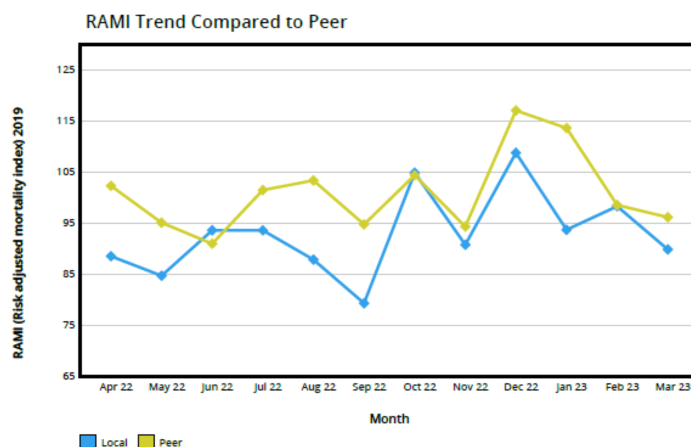


Chart. 11 RAMI trend to peer

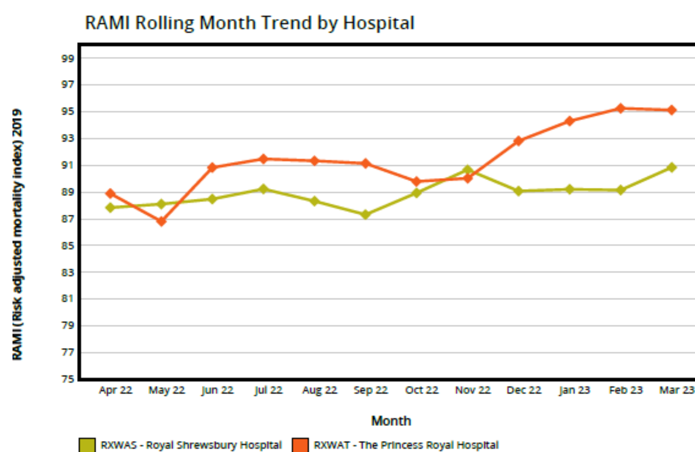


Chart. 12 RAMI Rolling Month Trend by Hospital

2.5 SHMI Details by Condition (Source CHKS):
In the latest available CHKS report, the primary diagnosis conditions with the top three highest number of 'excess' deaths (where there are more deaths than expected by the model) across the Trust are:

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

2.6 Deaths where anaemia is the primary diagnosis code:
A review has already been undertaken and reported in the Q4 2022/23 report. A further case record review will be undertaken if this condition remains one with the highest number of excess deaths.

2.7 Deaths where acute and unspecified renal disease is the primary diagnosis code:
An update was provided in the Q4 2023/24 report detailing ongoing actions being taken to progress improvement work relating to acute kidney injury within the Trust. The renal team maintain the strong recommendation 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.

2.8 Deaths where acute cerebrovascular disease is the primary diagnosis code:
This continues to flag in the top three conditions with the highest number of excess deaths across both sites. At RSH, the latest available SHMI data shows that it is the condition with the highest number of excess deaths. With the specialty stroke services within SaTH being based at PRH, a high-level assurance review of 25 patients is being undertaken between the Learning from Deaths team and the Stroke

Consultants, specifically focusing on those patients who have had a primary diagnosis code of acute cerebrovascular disease, and who have died at RSH with a relevant cause of death. The review aims to identify any concerns relating to the stroke pathway and to identify any wider learning which may be impacting on the excess deaths at RSH. As routine practice, 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.

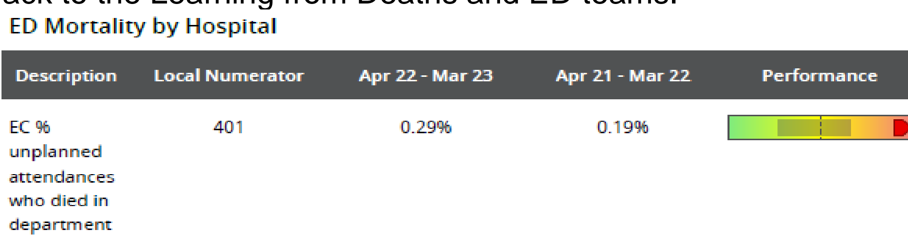
Initial findings reported to the learning from deaths group are positive, the deaths reviewed to date were expected, the care was appropriate and transfer to PRH and the specialist stroke team, was not considered appropriate. This review is ongoing with completion anticipated to be before the Q2 report is reported to the Board of Directors.

An internal monitoring process has been established by the Learning from Deaths team through the weekly Mortality Triangulation Group (MTG) meeting, to refer all deaths at RSH with a stroke related cause of death to the stroke consultants at PRH for a review of care.

2.9 Deaths where acute myocardial infarction is the primary diagnosis code:
This condition has not flagged for review before within the CHKS quarterly report, however the latest available data for both HSMR and RAMI identifies it as one of the conditions with the highest number of excess deaths across both sites. As such, the Learning from Deaths team will undertake an assurance review for the relevant cohort of patients with appropriate specialist input.

2.10 Deaths that occur within the emergency department:
Following the spike in deaths within ED during Q3 2022/23, the collaborative review with senior clinicians in ED as detailed within the Q4 2022/23 report remains in progress. This increase has also been reflected within the crude mortality performance relating to the percentage of unplanned attendances who died in the ED to March 2023 as seen at chart 13.
The Q4 2022/23 report detailed the approach to the review being taken. Significant progress has been made and no specific concerns identified to date. A full report is currently being finalised, the presentation of which is anticipated in September to the Trust Learning from Deaths group. The findings will be shared thereafter with the Board of Directors.

A report from CHKS is currently being prepared for the Performance and Information Team in SaTH, and as part of this the data quality within ED is being reviewed, which may potentially impact on the performance metric shown at chart 7. The findings will be fed back to the Learning from Deaths and ED teams.


ED Mortality by Hospital

Description	Local Numerator	Apr 22 - Mar 23	Apr 21 - Mar 22	Performance
EC % unplanned attendances who died in department	401	0.29%	0.19%	

Chart. 13

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

2.12 Responding to feedback from bereaved families is a vital part of the learning from deaths within the Trust. During Q1 2023/24, significant concerns were raised by the bereaved during Medical Examiner Scrutiny in 17 cases where the patient died. Formal complaints have been raised in 5 of these cases, and a serious incident investigation is in progress for 1 case. One case has been referred to Shropshire Community Health Trust for follow up as the concern expressed referenced a primary care issue. The remaining cases have either a datix investigation, divisional investigation or an SJR in progress, of which 5 SJRs have been completed at the time of writing this report.

2.13 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.

Over the last 12-18 months, performance relating to SJR completion has been challenging to improve due to operational challenges and resource availability within the divisions. Following the recruitment of additional resource to the Corporate Learning from Deaths team, assurance can now be provided to the Board of Directors that the 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 seen at chart 14. If this performance is sustained, sufficient data will be available in line with NHS England recommendations to appropriately identify themes and trends to inform quality improvement initiatives across the organisation.

In addition to measuring the number of SJRs completed each month with a variable date of death as seen at chart 14, the Learning from Deaths Dashboard overview as seen at Appendix B demonstrates performance relating to the percentage of deaths each month that have had an SJR completed. Again, a significant improvement can be seen as the percentage has increased from 2.1% as reported in the last quarterly report, to 8.7% for deaths that occurred within April 2023. This metric, combined with the number of completed SJRs each month, demonstrates significant improvement not only in the number of SJRs being completed but also with the timeliness of the these, to achieve completion within 8 weeks of death or mortality screening, in line with the Trust Learning from Deaths Policy.

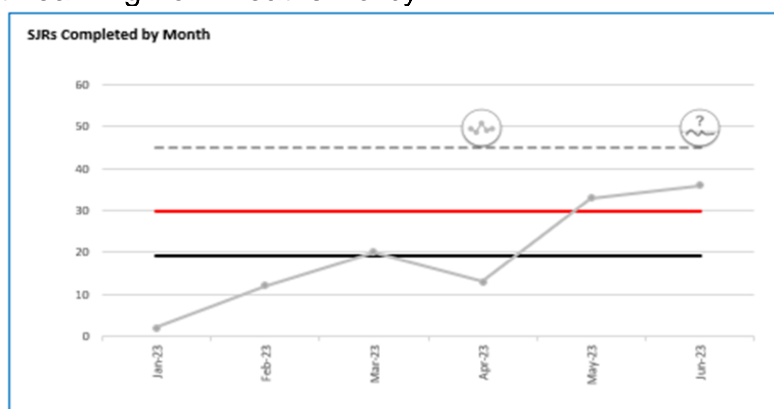


Chart.14 SJR completion by month

3.0 <u>SJR report for SJRs completed during Q1 2023/24</u>

3.1 81 SJRs have been completed during Q1 2023/24 which is more than the total number of SJRs completed for the previous full year 2022/23 (78). This section of the report presents key data from these reviews.

3.2 Care Ratings:

Over 50% of the completed SJRs during Q1 2023/24 identified an overall rating of good or excellent care (chart 15). However, in just over 10% of the SJRs, the overall care was rated as poor. Of these, 1 case has been reported as a serious incident investigation.

Care ratings are also provided for each phase of care for each patient as seen at chart 16.

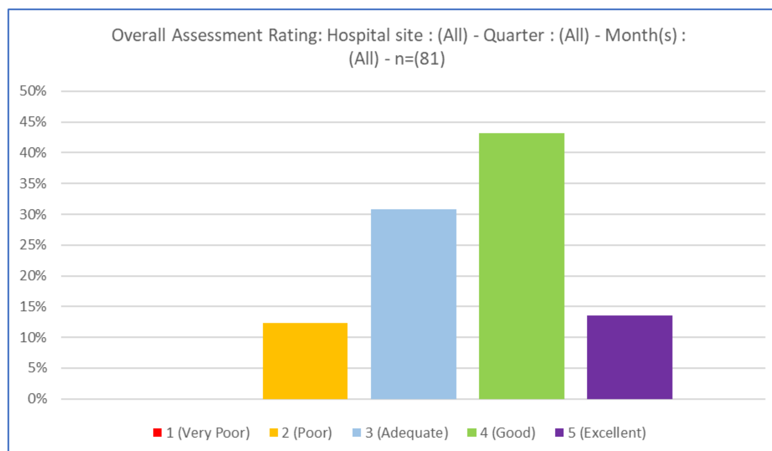


Chart. 15 Overall assessment ratings

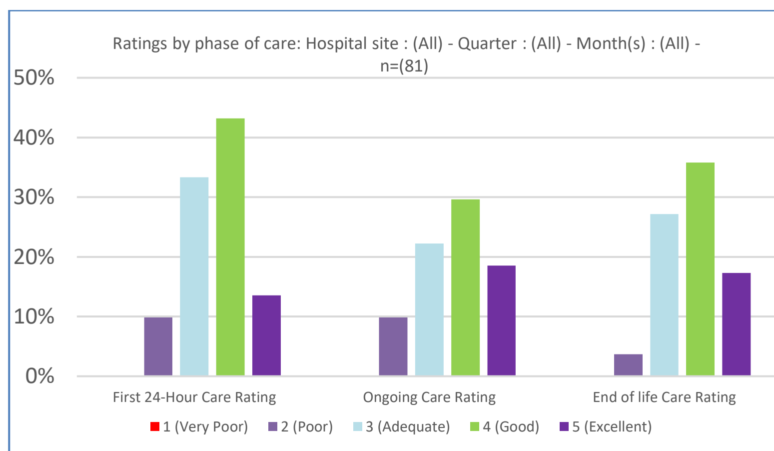


Chart. 16 Care ratings by phases of care

3.3 Examples of learning identified for cases where the care was rated as excellent:

Examples of excellent / good care identified within SJRs completed in Q1 2023/24
Evidence of regular / daily reviews of patients and appropriate response to nursing concerns
Prompt triage assessment and appropriate referral to specialist team
Administration of analgesia in ED
Timely and appropriate observations in ED including neurological observations
Communication with family and plan for EoL care / involvement of family in care
Use of ReSPECT and consideration of patient wishes / involvement of family
Comprehensive clerking of patient by Elderly Care team
Recognition of self-neglect / safeguarding referral
Appropriate investigations and management including AKI
MCA completion
Holistic medical clerking

Evidence of appropriate escalation of high NEWS2
Excellent nursing documentation demonstrating concerns and escalation
Commencement / completion of sepsis pathway as per protocol
Appropriate and timely assessments for nutrition and pressure areas completed
Safety check documentation evidencing regular monitoring of patient despite extended time in ED
Appropriate pathways of care in ED followed
Patient being provided with a comfortable and peaceful environment as possible at the end of life
Evidence of good teamwork / involvement of MDT including during extended stay in ED
Fast track discharge facilitated
Involvement of Palliative Care and End-of-Life Team
Involvement of dementia team
Following the death of the patient, family were offered follow up investigations for genetic screening – evident that this was handled very sensitively by those involved
Prompt use of anticipatory medications

3.4 Examples of learning identified for cases where the care was rated as poor:

Examples of poor care identified within SJRs completed in Q1 2023/24 through the documentation available
Ambulance offload delays
Delay in initial assessment in ED of several hours due to capacity
Delay in medical review of patients in ED due to capacity
Elderly patient with fractured hip required to sit in a chair in ED waiting room overnight due to capacity issues
Observations not recorded on Vitalpak potentially as patient in waiting room in ED not cubicle
Oxygen therapy apparently not initiated for saturations of 86% in ED, which were deemed abnormal for patient
Lack of nursing documentation despite length of time patient in ED / safety checklists / comfort charts incomplete. Suggestion from reviewer to incorporate the relevant charts into the CasCard
Nursing PIN number missing in documentation
Observations recorded outside of the protocol for NEWS2 in ED but noted that department under extremis
Delay in prescribed medications being administered in ED, including first dose antibiotics
No examination of skin / pressure areas of older patient in ED / pressure / monitoring of pressure areas during offload delays
No evidence of escalation to medical staff of issues including no urine output, new confusion / delirium
ReSPECT completion / documentation of rationale for decisions taken / ReSPECT form not given to patient on discharge and not scanned onto clinical portal as per policy
Problems with fluid balance monitoring and management of urine output in a patient receiving IV diuretics
Escalation of deterioration
Long gaps in of up to 12 hours in nursing documentation
Medical reviews over the weekend
Communication issues including between carers of a patient with learning disabilities and staff

Reports from relatives of patients left sitting in soiled bedclothes
Failure to recognise deterioration and dying / delay in commencement of EoL pathway
MCA documentation in cases where it would have been relevant
Transfer to mortuary prior to verification of death
Failed fast track discharge following inappropriate transfer of dying patient to an inappropriate clinical area instead of facilitating care at home.

3.5 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) score:
NCEPOD includes useful descriptors about organisational as well as clinical learning. All completed SJRs where the NCEPOD rating is recorded as 'less than satisfactory' are subject to additional review and consideration as a patient safety incident. In Q1 there were five cases that met this threshold (chart 17). Four of these cases have been reviewed through both the Trust and West Midlands Ambulance Service (WMAS) governance processes including divisional forums.

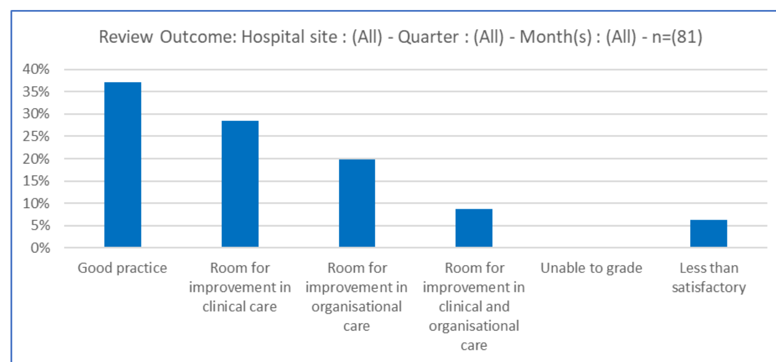


Chart.17 NCEPOD ratings

3.6 Preventability ratings in SJRs completed during Q1 2023/24:
SJR reviewers are required to provide their judgement as to whether the death was more likely than not due to problems in healthcare. An SJR that identifies preventability greater than 50:50 requires further investigation and is reported through the datix system.

Two cases in Q1 2023/24 were recorded as being potentially preventable greater than 50:50. The West Midlands Ambulance Service Patient Safety Team / Learning from Deaths Lead, reviewed the care for one of these cases and no concerns were raised regarding delay with the ambulance. The case did not meet the threshold for reporting as a serious incident. The second case is currently being reviewed through the datix system.

3.7 Length of stay:
Over 40% of the patients whose care was reviewed using the SJR during Q1 2023/24 had a length of stay between 1 and 6 days before they died. A detailed breakdown is provided at chart 18.

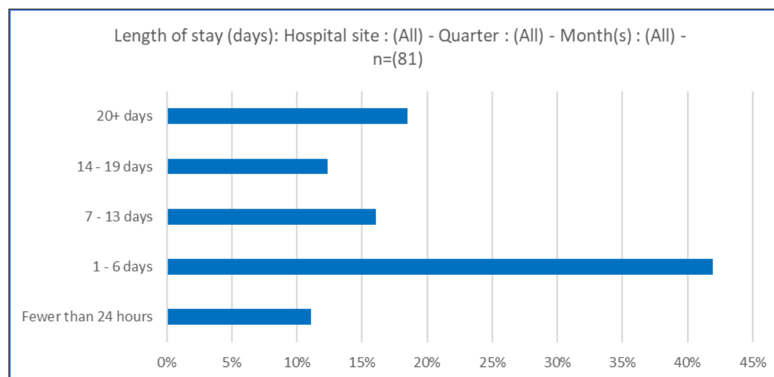


Chart.18 Length of stay

3.8 Cases flagged as readmissions during SJRs completed in Q1 2023/24:
Just over 20% of the patients reviewed during Q1 2023/24, equating to 18 patients, were identified as readmissions to hospital.

Specific learning identified from original discharge / readmission:

Discharge / readmission concerns identified in completed SJRs
Direct GP referral to surgeons would have been appropriate instead of sending patient to ED as known surgical problem with planned follow up, which was treated during previous admission. This may have prevented a 24 hour stay in ED
GP communication suggested failed discharge, however evidence of MDT approach to discharge with agreement from all specialities that discharge was appropriate. Patient was keen for discharge; the ceiling of care had been reached and the patient understood and accepted the risk of further deterioration. A referral had been made to community PCEoL team.
Patient admitted from clinic feeling unwell and a deterioration in their condition and observations, following discharge the previous day. The decision to discharge was not deemed unreasonable.
Patient under the renal team with a complex history, had been discharged three days previously, awaiting results of an investigation. Patient with full capacity, wanted discharge with follow up with the dialysis team. On readmission to ED, was referred to the renal nurses for review. Deteriorated quickly and sadly died.
Patient with a complex medical history and relatively rare condition. Recently moved to area and recent discharge. Formal complaint in progress.

3.9 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. Of the 81 completed SJRs, 4 patients within the cohort were described as having a mental health issue and 5 patients were identified as having a learning disability. Examples of good and poor care are provided below:

Examples of positive and negative learning identified within MEC 2022-23	
Negative	**Positive**
Monitoring of food and fluid intake	Early consideration of ReSPECT
Limited support provided from the acute liaison team	Good escalation of concerns and deterioration evident
Completion of Mental Capacity Act documentation / ReSPECT forms	Quality of care from individual staff highlighted by relatives
Escalation of deterioration	Good multi-disciplinary team involvement with care
Need to improve documentation around rationale for removal oof indwelling catheter	Update of existing ReSPECT forms

End-of-life care pathway not used	Legal Power of Attorney was kept up to date and consulted on regarding decisions to be taken.
Communication issues including involvement of family with decision making, lack of clear explanations to family	Excellent documentation of meeting with parents by consultant – 3 options discussed with associated consequences.

3.10 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 the SJRs completed within Q1 2023/24, demonstrates that the percentage of patients who showed signs of confusion, including delirium is now in line with the benchmarked figure and equates to 33.3%. Since December 2022, the Learning from Deaths team have undertaken a considerable amount of work to refine SJR case selection whilst wider improvement work within the Trust relating to the identification of new confusion and the documentation of delirium is likely to have also had a positive impact.

3.11 Problems in Care identified within completed SJRs Q1 2023/24:
SJR reviewers are invited to identify problems in care according to the categories as per chart 19 below. 'Problems in care' were identified in 58 out of the 81 SJRs completed during Q1 2023/24. The Pareto chart at chart 19 reflects the number of times each problem was identified. Cases may have more than 1 problem identified.

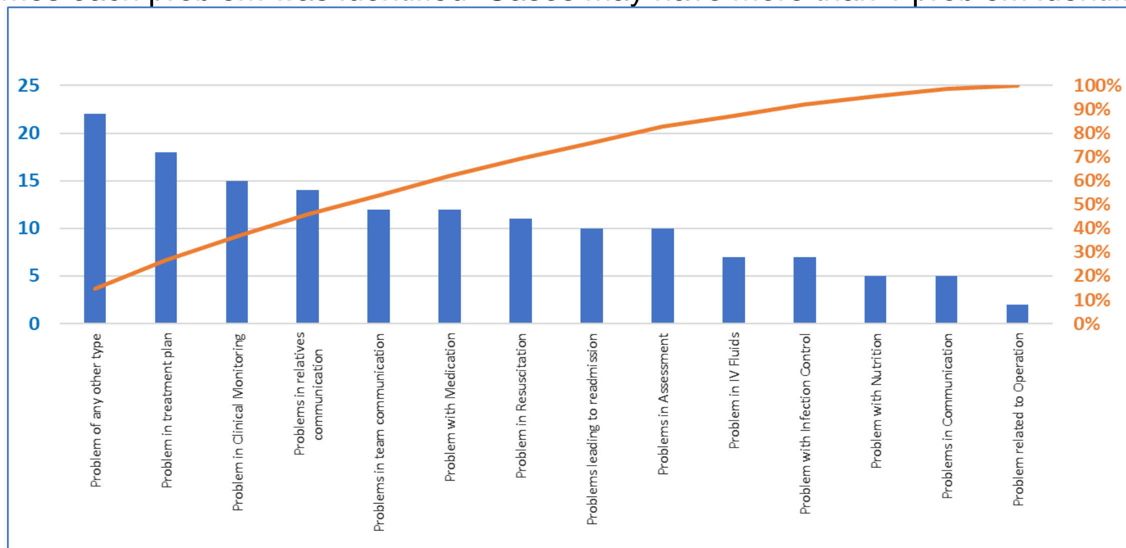


Chart.19 Pareto chart showing problems in care: SJRs completed Q1 2023/24

More details about the problems in care identified during the SJRs have been detailed at section 3.4

4.0 <u>Learning identified through wider learning from deaths processes across the Trust</u>

4.1 Themes noted through Mortality Triangulation Group (MTG) within Q1 2023/24 include:

- Concerns around ambulance offload delays and ambulance pickups 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. Cases where a patient safety incident has been identified are managed through the datix system and potentially through the Trust Serious Incident Policy.
- Discharge issues noted through Medical Examiner Scrutiny. These cases are managed through MTG on an individual basis depending on the concern identified.
- Lack of documented medical review over a weekend.
- Patients deemed medically fit / optimised for discharge (MFFD / MOFD) but then deteriorate and die. In particular, MTG is monitoring cases where the patient was deemed MFFD / MOFD but then developed an hospital acquired infection which is noted on the death certificate.
- Death following readmission to hospital - cases where the patient has been readmitted following a recent discharge and then dies. The reason for readmission is considered and relevant cases may be forwarded for an SJR unless being managed through an alternative process.
- End-of-Life care – in this quarter, MTG continues to identify both positive and negative learning relating to end-of-life care. Relevant cases are referred to the End-of-Life team for further review and learning is shared thereafter with the End-of-Life Steering Group as appropriate. Key themes identified in Q1 2023/24 remain consistent from previous reports and relate to issues with pain relief / anticipatory medications, delay in commencing end-of-life care / recognition of deterioration, communication issues, fast track discharge issues, and ReSPECT form issues.
- Medication issues continue to be a key theme identified and monitored through MTG especially cases which have not previously been flagged through the datix system. Concerns relating to medications are referred to the Trust Medicines Safety Officer for review within the Trust and / or Integrated Care System (ICS) as required. Specific concerns raised during this quarter include concerns with:
  - The prescription of penicillin-based antibiotic when the patient has a penicillin allergy.
  - Opioid toxicity requiring naloxone.
  - Prescription of Alteplase.
- Recognition of deterioration.
- Documentation issues.
- Cross-site and inter-hospital transfer issues – these cases are referred to the Patient Safety Specialist in the Trust to assist the current review into transfers of critically ill patients that is currently in progress.
- Delayed verification of death.

4.2 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 Q1 2023/24, 26 ‘You are appreciated’ cards have been shared appropriately.

4.3 Learning from Coronial Proceedings

A number of inquests closed during Q1 2023/24 involved patients who died elsewhere. Identified learning was therefore only available for the other providers.

The main learning point for the Trust arising from coronial inquests in this quarter highlighted the importance of pre-inquest meetings with families. If held, these may avoid the need for attendance at hearings and or requests for multiple statements.

4.4 Example of specific positive and negative learning from deaths identified by the Medicine and Emergency Care and Surgical and Cancer care Division relating to patients who have died during Q1 2023/24 during is shown below.

Examples of positive and negative learning identified within MEC 2022-23	
Positive	**Negative**
Early sepsis, hypoglycaemia and hypokalaemia treatment and good nursing assessments	Observations not adequately recorded
Good assessment and escalation of patient	Delay in treatment and diagnosis
Good end-of-life care	The patient had many reviews where the early warning score was high and the patient was deteriorating. Earlier recognition of this would have helped the on-call teams and the patient and relatives to plan for end-of-life.
Good care from consultant – comprehensive review, communication with patient and family	Medical review not carried out to a sufficient level
Patient's wishes about condition and desire not to be operated on were acted upon	Possible missed opportunity to call family in if the patients deteriorating condition had have been recognised earlier
	Miscommunication in ED notes led to an initial misdiagnosis of a patient

5.0 LEARNING: ACTION: IMPACT: Turning learning into improvement:

5.1 The information obtained through the wider Learning from Deaths agenda is signposted through to clinical and non-clinical teams within the Trust for review and analysis within the context of their own specialist programmes of work. In turn, this intelligence then supports and informs quality improvement initiatives within those areas as well as the Trust as a whole. Close links have now been established between the Corporate Learning from Deaths team and a variety of internal and external stakeholders including Shropshire Community Health Trust, West Midlands Ambulance Service Patient Safety Team, the Trust Specialist Fluid Balance Nurse, Deteriorating Patient Team, Palliative Care and End-of-Life Team, Trust Medicine Safety Officer, as well as the Divisional Quality Governance Teams and clinical staff. The sharing of information is now a vital part of 'business as usual' as we strive to improve care for the patients and communities we serve.

5.2 Examples of quality improvement work arising out of the information the learning from deaths collates and appropriately shares are given below.

5.3 Antibiotic prescription and patients with allergies
As detailed at section 4.1, there have been several incidents noted through MTG where a prescription has been written for a penicillin-based antibiotic, for patients who are allergic to penicillin. Following referral to the Medicines Safety Officer (MSO), this has been raised with the antibiotic pharmacy team. As a result, the Trust antibiotic guidance is being updated to include alternatives for patients with allergies and a Trust 'One Minute Brief' has been released to staff. Plans to monitor compliancy with this thereafter will need be established.

5.4 Direct oral anti-coagulant (DOAC) use in the elderly
Cases were raised through MTG with the MSO following the identification of patients who had fallen whilst on Apixaban and had a cerebral bleed. A medication review is included within the Trusts post fall policy and also where patients are receiving 4 or more medications. The pharmacy team are working on reviewing all patients who are at high risk of falls. Training is to commence for Pharmacy staff from the Falls

Pharmacist in relation to medication reviews with this group of patients which will be supported by useable guides. The medication policy is to be updated to include guidance for reversal agents.

5.5 Parkinson's medication / Time Critical Medicines
Links with the Learning from Deaths team and the referral of specific cases where a problem has been identified, is contributing to work being undertaken by the pharmacy team supporting patients with Parkinson's Disease to receive their essential medications on time. This work is being assisted by access to training materials which demonstrate why timely administration of this group of medications is important.

5.6 Chronic pain and the use of morphine
Following referral to the MSO of a case where the patient died following an accidental overdose of morphine which had been prescribed to be administered on a 'PRN' basis (Pro-re nata – as needed), and the release of a national alert regarding opioid use, a programme of work is being undertaken with the Shropshire, Telford, and Wrekin Integrated Care Board (STW ICB) and within SaTH and the Improvement Team. Key improvement aims within SaTH relate to compliancy with opioid dispensing on discharge and the completion of a Discharge Medicines Services (DMS) Referral for relevant patients. This work has been progressing since January 2023 with significant improvement reported to date.

5.7 Learning from Deaths and deteriorating patient and sepsis improvement work
The Learning from Deaths programme of work continues to support the wider deteriorating patient and sepsis improvement work within the Trust through the appropriate referral of specific cases and through sepsis validation work undertaken for cases identified through MTG or mortality screening. Regular updates of this work to the Trust Learning from Deaths Group are provided by the Deteriorating Patient Nurse Practitioners.

6.0 <u>Deaths of Patients with a Confirmed Learning Disability</u>

6.1 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. As such, all patients with a confirmed learning disability or autism who die are referred to the service improvement programme for people with a learning disability and autistic people (LeDeR). An external review is then undertaken to identify learning by reviewing key episodes of health and social care the person received that may have been relevant to their overall health outcomes.

6.2 To support the external LeDeR review, an internal SJR is mandated for all patients with a learning disability who die whilst receiving care as an inpatient in the Trust or within the ED. On completion, this is then forwarded to Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) for inclusion in the external LeDeR review.

6.3 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.

6.4 In Q1 2023-24 there were 2 patients with confirmed learning disabilities, who died in the Trust either as an inpatient or in the emergency department. Both cases have been reported to LeDeR. One SJR is complete and the other one is in currently in progress.

6.5 In the one completed SJR, positive learning was identified for the respiratory team, where it was felt the care and documentation was excellent for the patient. One area for improvement related to documentation around admission to ITU and the need to provide more documented evidence around the clinical reasoning which supported the decision not to admit to ITU or provide more invasive care.

6.6 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. The Board of Directors can be assured that these reviews are all now completed.

7.0 Deaths of Patients with a Serious Mental Health Condition (SMI):

7.1 All deaths within the Trust where an SMI is confirmed are referred for a mandatory SJR to identify and maximise learning opportunities unless another review process in underway. The Specialist Mental Health Nurse in the Trust provides a specialist review to support the clinical input to the SJR.

7.2 In Q1 2023-24, there was 1 death of a patient identified with an SMI. This case has been referred to the coroner and remains open. This process will supersede the requirement for an SJR.

7.3 The Q4 2022/23 report detailed outstanding SJRs for patients who died in the Trust with a confirmed SMI. To date, 4 of these still remain outstanding.

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 Q1 2023-24.

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

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

Terminations of pregnancy	All terminations of pregnancy after 22+0 and all terminations from 20+0 weeks which resulted in a live birth resulting in a neonatal death	0

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 Q1 2023/24, 11 perinatal mortality reviews have been undertaken in the Trust. Identified learning relates to:

- The need for pregnant patients taking anti-psychotic medication to be referred for a glucose tolerant test.
- The need to evidence the administration of a patient's usual medication during their inpatient stay on delivery suite.
- The need for an antenatal clinic appointment at 24 weeks gestation when the patient has had a previous caesarean section.
- The requirement to ask all pregnant patients at booking about domestic abuse.
- The requirement for comprehensive completion of the partogram used on delivery suite to monitor and record progress in labour.
- The requirement to calculate VTE status for a pregnant patient following a positive result for COVID-19.

8.7 No serious incidents relating to perinatal mortality have been reported to StEIS during Q1 2023/24

9.0 Paediatrics

9.1 During Q1 2023/24, there have been 3 paediatric deaths managed by the Trust Medical Service. Two of these were an inpatient and one was being cared for in the ED at the time of death. None of these deaths have a related serious incident investigation in progress.

9.2 One serious incident relating to a child death was reported by the Trust to StEIS during Q4 2022-23. At the time of the Q4 2022/23 report, this investigation was open. This investigation has now been closed and the death was not deemed to have been potentially preventable. A detailed summary of learning identified within this investigation 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.

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. This will be replaced with the new Patient Safety Incident Response Framework when it is implemented within the Trust later in the year.

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. Following serious incident investigation, deaths judged more likely than not to have been due to problems in healthcare and therefore potentially preventable 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.

10.3 In Q1 2023/24, there have been 8 serious incidents relating to patients who have died, reported externally to the Strategic Executive Information System (StEIS). At the time of writing this report, all 8 investigations remain open. Two of these serious incidents relate to a patient who did not die in the Trust.

10.4 The Board of Directors 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.

11.0 Risks

11.1 There is one risk that remains on the Trust Risk Register relating to recruitment within the Learning from Deaths team. Since the previous Q4 2-22/23 report, 3 SJR reviewers have commenced in post, therefore the only post that currently remains vacant is the band 5 Support Officer post. Whilst this was initially recruited to in September 2022, the postholder has now left the position following an extended period of sickness since January 2023. This vacant position places significant demand on the team to support the and maintain the continued development of learning from deaths programme of work.

11.2 Appropriate office space accommodation has not yet been identified to house the expanded Learning from Deaths team despite in June 2022, having been escalated appropriately through the Trust process for requesting additional office space. 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 team members, which is essential to progress the wider learning from deaths agenda within the Trust.

11.3 Without identified specialised resource to support mandated SJRs undertaken for patients with a confirmed learning disability or autism diagnosis, as detailed at section 6.3, the Trust is at risk of failing to maximise learning opportunities and improve care for this group of vulnerable patients. As such, there is the risk of potential reputational damage if internal learning is not identified before the external LeDeR takes place.

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

July 2023

Appendix A: Medical Examiner and Bereavement Service Q1 2023/24 report

MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT
QUARTER 1 – APRIL – JUNE 2023

1.0 Introduction

1.1 The purpose of this report is to provide the Trust Board with an overview of the number of in-hospital deaths managed by the Medical Examiner & Bereavement Service during Q1 (April-June 2023/24) and the outcome of Medical Examiner reviews, including those with coroner involvement.

2.0 Number of Hospital Deaths

2.1 There were 546 deaths across both hospital sites during Q1 recorded by the Bereavement and ME service, which was a reduction of 79 deaths reported in Q4, however an increase of 28 deaths from the same period in 2022 (Figure 1).

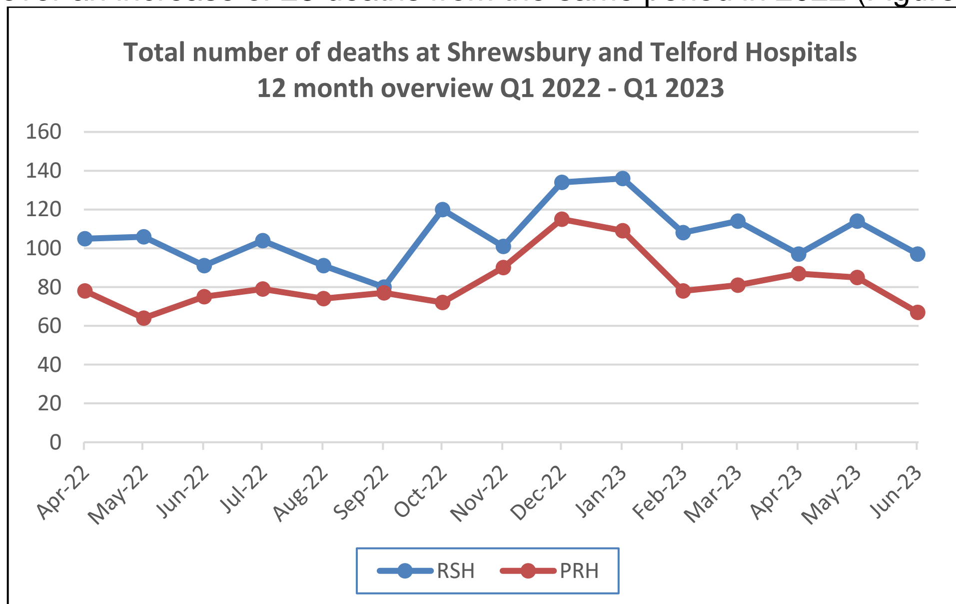


Figure 1 – Total number of deaths at SATH 12-month overview

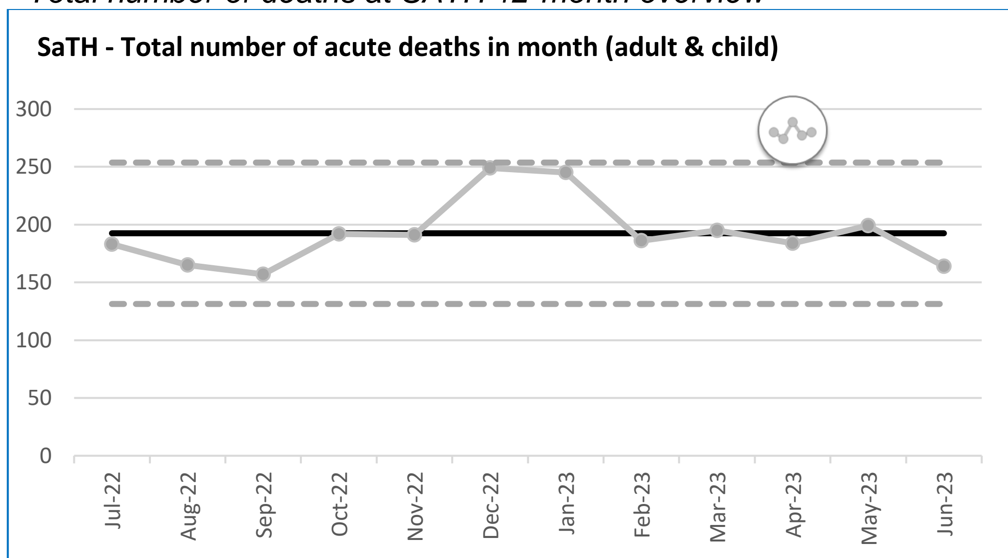


Figure 2 – SaTH – SPC of acute deaths in month (adult & child) – 12-month overview

You will note from figure 2 that trust has on average 150-200 in-hospital deaths a month currently across both sites, with the winter period of Q4 reaching nearly 300 deaths which is nearing the upper process limit point.

2.2 Acute hospital paediatric deaths

There were 3 paediatric deaths in Q1 that occurred at PRH, 1 case in ED and 2 ward cases. 2 of the cases were reviewed by the ME service. 1 case was directly referred to the coroner by the police, which proceeded to a postmortem investigation.

2.3 Acute hospital adult deaths

There were 455 inpatient deaths across both sites in Q1 and 91 deaths in the Urgent Emergency Care Departments (including the 3 paediatric cases) during this quarter (Figure 3).

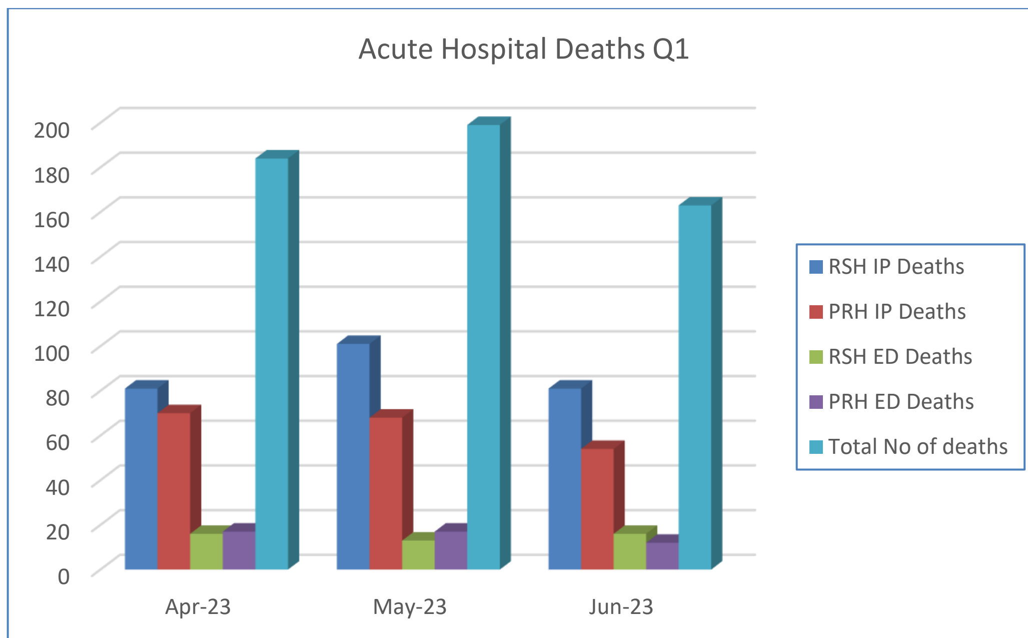


Figure 3 – Acute hospital deaths split by site, inpatient & UEC in Q1

2.4 Deaths in patients with Covid-19

There were 28 deaths reported for patients who had a positive covid-19 PCR result in the preceding 28 deaths prior to their death in Q1 (Figure 4). This is a reduction of 54 from the previous quarter.

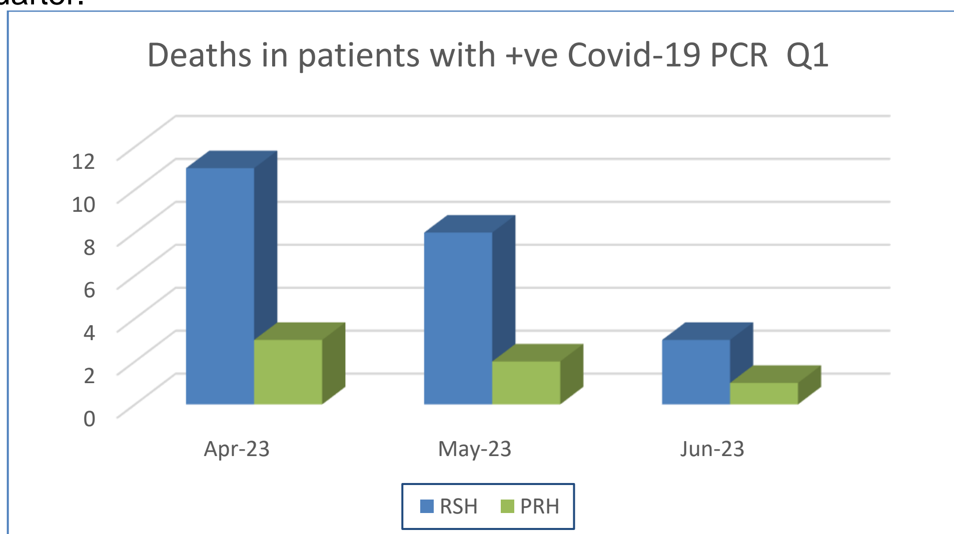


Figure 4 – Number of patient deaths with positive covid-19 PCR

A 12-month summary overview of the covid-19 deaths is seen in Figure 5 where it can be seen there was a reduction of deaths from quarter 4.

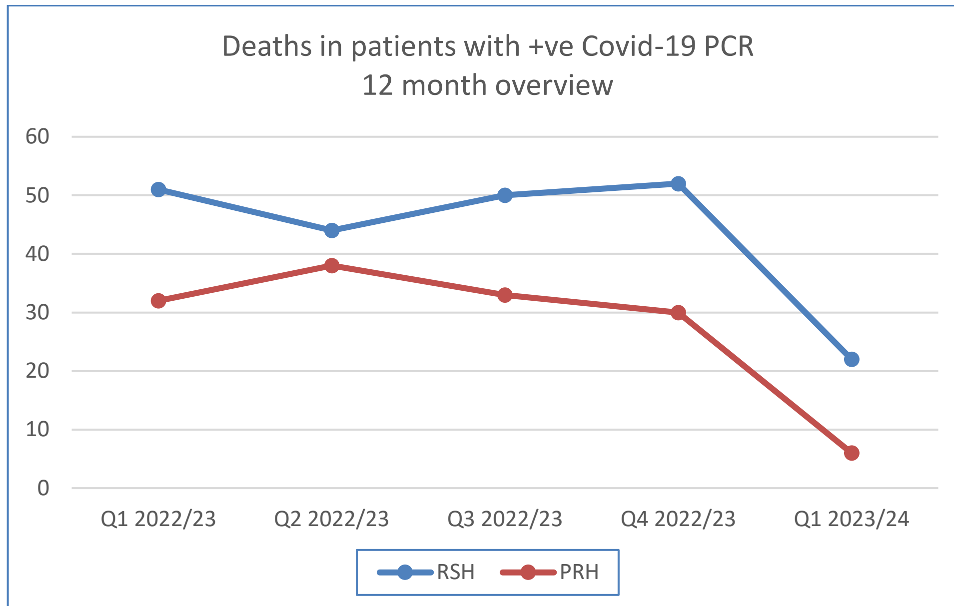


Figure 5 – 12-month summary overview of covid-19 deaths for patient with a positive PCR

Since the beginning of the Covid-19 pandemic, the bereavement team have had the responsibility of ensuring all deaths in patients with a positive covid-19 result were reported to CPNS data collections. On the 18th May 2023 we received notification from NHS England (Appendix A) that they will cease collecting data, where an individual has died with a positive covid-19 result, via the CPNS system from the 30th June, and will instead use death certification to process this information as with other infectious diseases.

This will therefore be the last quarter where deaths in patients with a positive covid-19 result will be highlighted in this report.

3.0 Medical Examiner Review Scrutiny

3.1 Summary

537 of the deaths that occurred in Q1 received Medical Examiner Officer preparatory review and 543 received Medical Examiner scrutiny (Figure 6), 99% of the overall deaths therefore receiving a review. Of these 99% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment and cause of death. The remaining 4 cases of contact not made was due to a combination of no next of kin available, relatives not returning our calls and 1 case where the police had referred the death to the coroner directly.

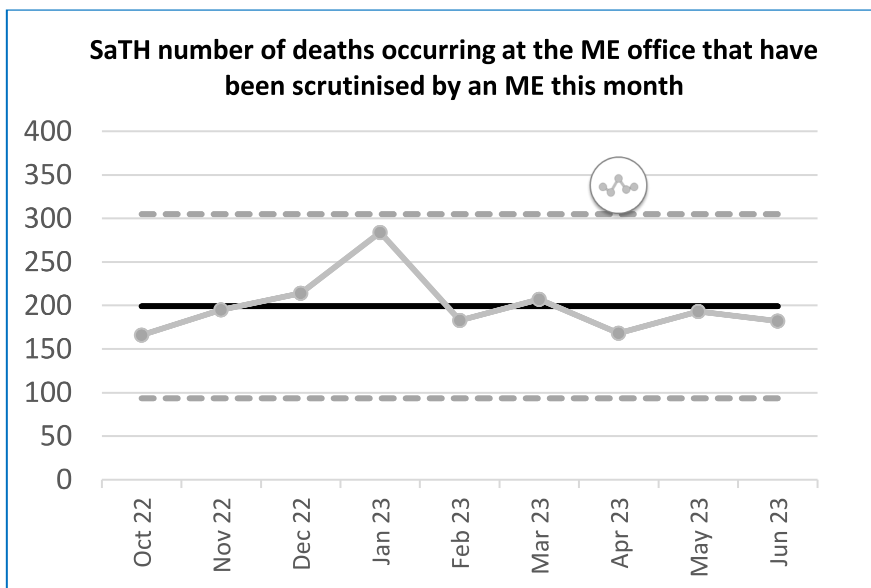


Figure 6 – Total Number of Medical Examiner Reviews in 9 month overview

You will note from the above SPC chart that the Bereavement and ME service can expect to receive an average of 150-200 deaths a month currently across both sites, with the winter period of Q4 reaching nearly 300 deaths which is nearing the upper process limit point.

3.2 Deaths identified by Medical Examiner for potential learning

Out of the 543 reviews completed during Q1, the Medical Examiners raised potential learning in 79 deaths, with all these cases being referred to the relevant clinical divisions and specialties for review through their governance processes to ensure learning can be shared. This is a reduction of 2 cases from Q4.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 543 deaths reviewed by the ME service, 496 MCCDs were requested following the Medical Examiner review and completed by the treating clinician.

4.2 Of the 496 MCCDs written, 435 of these had no coroner involvement and so the target timeframe for MCCDs with no coroner involvement to be written, is within 3 calendar days. 152 of the MCCDs were not completed within 3 calendar days during Q1. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time.

Performance in this area has been challenged since the withdrawal of the emergency covid legislation and responsibility of the completion of MCCDs retuned to the treating clinician.

You will see in the SPC chart below (Figure 7) that the delays with writing MCCDs peaked significantly in January 2023. Collectively across both sites we average between 40-50 MCCDs each month being completed beyond the 3 calendar days. There was a rise in May which can be attributed to the extended bank holidays during that month followed by junior doctor strikes.

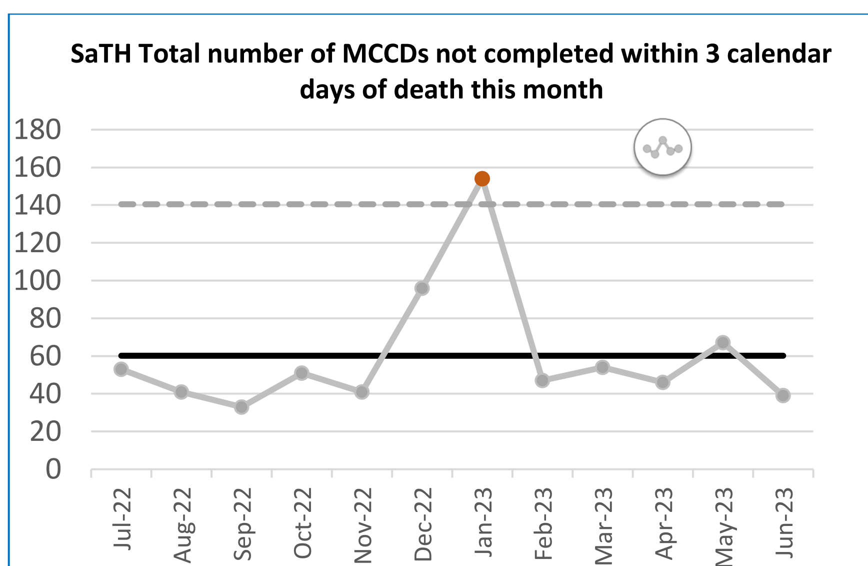


Figure 7 – Number of MCCDs not issued within 3 calendar days of death

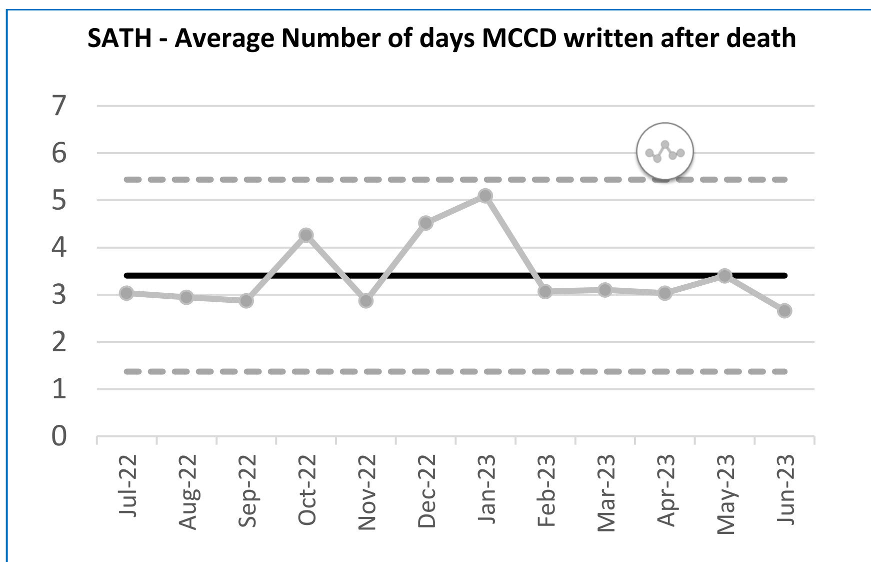


Figure 8 – Average number of days MCCD written after death

Our performance in respect of meeting 3 calendar days is being monitored by the Regional Medical Examiner and has been a point of discussion following quarterly submissions to the National ME. This is seen as a risk to our performance and has been highlighted in previous reports with support requested from senior clinicians to release their clinical teams to complete death certification seen as a priority. This has been further supported by the Medical Directorate. We continue to keep the Registration services appraised of any cases where there will be a delay in facilitating registration.

4.3 MCCDs rejected by Registration Services

Although all adult deaths are reviewed by the Medical Examiner, and a sign off from this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD we have provided. In these cases, the Registrar will either contact the Bereavement Service to discuss the cause of death, or they will refer the death directly to the coroner. Of the 496 MCCDs written and issued, 4 certificates were rejected by Registration Services in Q1.

5.0 Structured Judgement Review

5.1 There were 36 deaths in Q1 (Figure 8) where the Medical Examiner had recommended an SJR, which is a reduction of 1 from what was requested in the previous quarter.

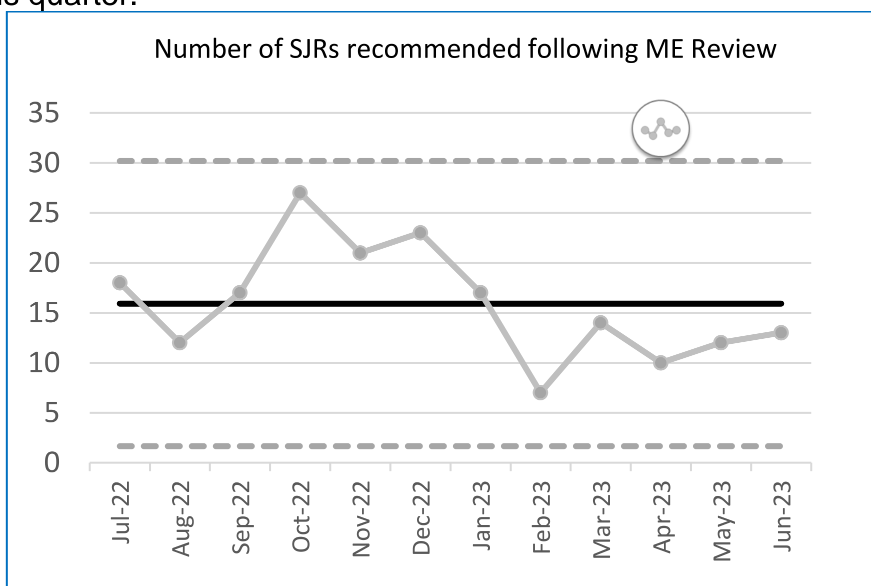


Figure 8 – Number of SJRs recommended following Medical Examiner Review

The SPC chart explains that typically the ME service can recommend on average SJRs in 15 cases a month, but you will see periods where the number recommended have got close to the upper and lower process limits with this correlating with seasonal variance.

Figure 9 below shows the categories for which the Medical Examiner has recommended an SJR review take place. The subject titles are pre-determined options that the Medical Examiner selects from the national exemplar Medical Examiner scrutiny paperwork. The cases that are identified for SJR by the Medical Examiner are then discussed at the weekly mortality triangulation meeting to facilitate SJR review to take place.

Number of SJRs recommended following Medical Examiner Review

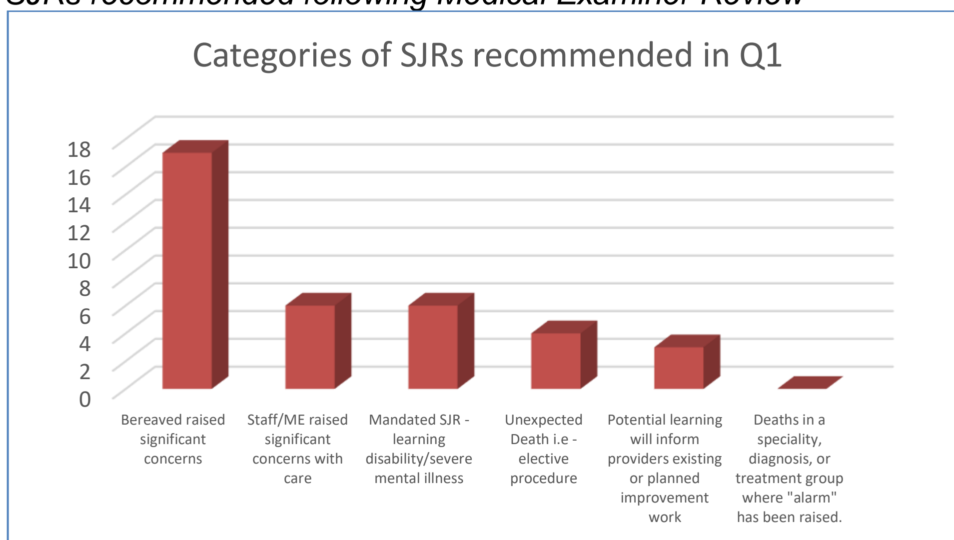


Figure 9 – Categories of SJRs recommended

6.0 Coroner Referrals

6.1 Summary

Across both hospital sites the Medical Examiner facilitated 105 referrals to the coroner during Q1. This is a reduction from what was referred in Q4 by 10 referrals.

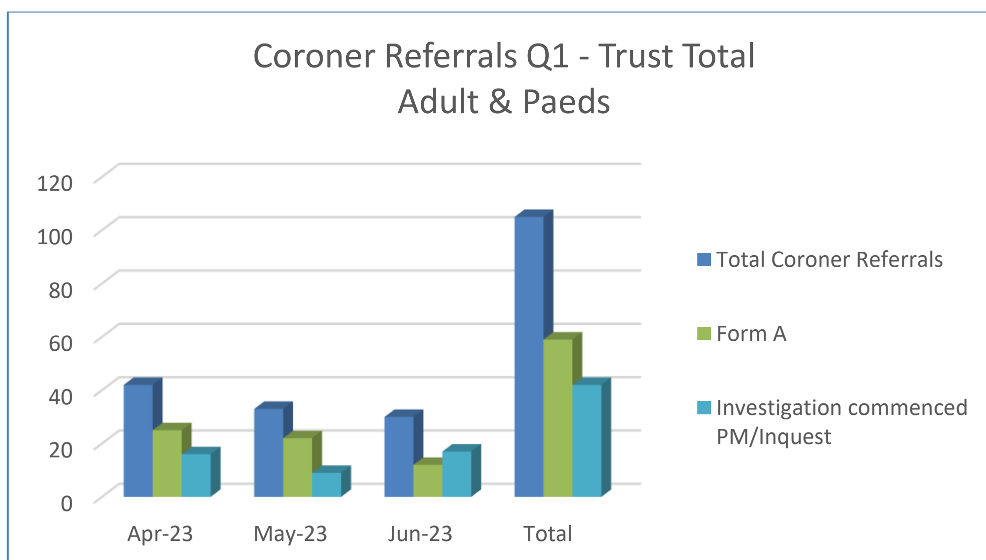


Figure 10 – Coroner referral outcomes Q1

Of the 105 referrals for deaths on both hospital sites, the coroner took no further action in 59 of the cases by issuing a Form A, and took 42 cases to investigation by either postmortem or inquest. The remaining 3 cases were followed by the GP who issued MCCDs.

It was referenced in the Q4 report that the Regional Medical Examiner does not support the Medical Examiner referring a death to the coroner, however, on checking this point at the National ME Conference in May, it was considered by the panel that although this might not be routine practice across ME offices, it is allowed practice. Despite this, it is recognised that returning this practice to the clinicians would free up capacity in the ME office, so to support the eventual roll out of ME review to the community, and so this practice does require review so to ensure best practice is being undertaken.

7.0 Urgent body release/faith requests

7.1 There were 2 requests for urgent body release for faith purposes in Q1, and both requests were facilitated in the timeframe required.

8.0 Service Highlights / Non-Acute Rollout

8.1 On the 27th April the National Medical Examiner released a statement (Appendix B) to advise that the Government had confirmed the next steps in the ME system becoming statutory (Appendix C). The statement confirmed that the commencement of the statutory period will take place from April 2024 with relevant provisions of the Coroners and Justice Act 2009 and the Health and Care Act 2022 will be commenced by autumn 2023. Despite this delay to the system becoming statutory, the service has continued with the established project plan to provide ME review to all deaths in ST&W.

8.2 Extension of the ME service to the community continues to be part of the organisations 'Getting to Good' programme with the service providing regular updates to that group to discuss progress against the plan on a page, provide reassurance against milestones and seek support and direction on the areas deemed to be risks to the delivery of the project.

8.3 Currently the service undertakes approximately 2000 medical examiner reviews per year and a forecast for the increased demand has been provided by the regional ME is expected to reach circa 5164 reviews per year. To manage this new demand from local community providers the regional team recommended and funded SATH's ME establishment to increase to 18 PAs. Recruitment undertaken during the previous quarter for additional medical examiner sessions has seen 2 new MEs start in post to assist with the additional demand the service can expect, however there has been 1 resignation during this time, meaning the service has 2 vacant sessions. These are specialised roles requiring at least five years' experience as a registered medical practitioner and now that the service has conducted 3 recruitment drives in recent months, it has been decided to proceed with conducting potential recruitment from seeking expressions of interest from internal clinicians, to support the plan for community rollout.

8.4 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 23. 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 very much anticipated that the business case will be approved 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.

8.5 In order to ensure the mandated target date is reached and with agreement from the Regional Medical Examiner, a pilot with Stirchley Medical Practice was undertaken throughout April which was very successful and is now business as usual. The ME service now routinely accepts and reviews the deaths of patients registered at this

practice. At the time of writing the service has reviewed 15 deaths and prevented 3 of these cases having the MCCD rejected by the registrar. Feedback from families who the service has liaised with is that they were glad of an independent doctor to speak to in respect of their relative's care, treatment and cause of death.

Accepting referrals from the Robert Jones Agnes Hunt Orthopaedic Hospital commenced in June with the service receiving 1 referral at the time of writing. A phased approach to rollout will take place thereafter once the service is fully recruited and confident in new operational processes.

8.6 Access to patient health records has been granted from the majority of community providers in STW however, through close engagement with the STW Local Medical Committee representing the 51 GP practices in the system, Information Governance colleagues and other Medical Examiner services in England who have already rolled out, it has been agreed the most appropriate means in which to access GP records is through 'EMIS viewer'. This is a cloud-based extension to EMIS providing reading access only and will provide the most efficient ways of working for both the SATH Medical Examiner service and local GPs. A wider discussion has taken place between SATH and the ICS and agreement has been reached for the ICB to fund the recurring cost of this electronic system so that rollout to ST&W GPs can take place. This is now going through the procurement process with training on the system to be arranged during Q2 of 2023/24.

8.7 In April 2022 the COVID Act was repealed and the completion of Medical Certificate of cause of Death (MCCD) and cremation form 4 had to return to the treating doctor who had seen the patient alive in the preceding 28 days. Completion of cremation form 4 has a fee attached and it is important that the financial governance framework around this payment is enhanced. A paper was written with an options appraisal for how remuneration could be re-introduced to the completing doctor whilst ensuring financial governance is maintained. This was presented to the Remuneration Committee and went forward to the Local Negotiation Committee for approval of the option for 60% of the fee being paid to the doctor completing the form with 40% being retained by the Trust for the administration attached to processing the forms. This is now being put in an operational procedure and it is anticipated this will come into place during Q2 of 2023/24.

9.0 Risks

9.1 Should the internal expressions of interest recruitment round not be successful to increase Medical Examiner sessions this will be a risk to further rollout of the non-acute service and an alternative approach to securing Medical Examiner sessions will need to be reviewed. It is a possibility to offer additional sessions to current Medical Examiners who may have the flexibility in their job plan to take on additional sessions. This model does come with operational challenges in that the more sessions one individual undertakes, the greater the impact to the rota in times of leave and sickness.

9.2 The organisation is required to review its bereavement function to ensure it is fit for purpose or there is risk funding will be removed from the Regional Medical Examiner. A decision is pending from the IIC to secure additional bereavement personnel, should this not be granted risk of MEO funding being withdrawn is significant.

9.3 The office accommodation at RSH for the Bereavement & ME service is challenged and not fit for purpose. The trust's process for requesting review of accommodation has been followed and commenced in Summer 2022. Despite this, there has been no progress against this action and it remains a risk to the expansion of the ME

service as we recruit additional staff members and have clearer definition between the service function of Bereavement and ME services. This is currently a milestone on the project plan overseen by the “Getting to Good” programme that is off track.

10.0 Summary

10.1 In summary the performance of the Bereavement and Medical Examiner service during Q1 remained challenged in respect of issuing MCCDs within 3 calendar days, due to the availability of the treating doctor attending to complete death certification. The challenges in our performance for issuing MCCDs does require senior leadership support to ensure there is a clear expectation of clinicians to provide timely support to this process.

Lindsay Barker
Medical Examiner and Bereavement Service Manager
July 2023

Appendix B: CHKS Peer group

- Royal Cornwall Hospital NHS Trust
- East and North Herefordshire NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Bedfordshire Hospitals NHS Foundation Trust
- Northen Care Alliance NHS Foundation Trust
- United Lincolnshire Hospital NHS Trust
- County Durham and Darlington NHS Foundation Trust
- East Lancashire Hospitals NHS Trust

Appendix C: Overview of the Learning from Deaths Dashboard

Shrewsbury & Telford NHS Trust

Context

SHMI

Latest month	Jan 23
SHMI	88.89
SHMI in expected range	
Observed deaths	223
Expected deaths	251

SHMI - Expected Vs. Observed

Trust SHMI - Observed Deaths
Trust SHMI - Expected Deaths

Hospital Occupancy

Latest month	Jun 23
%	90.1%

No significant change

% Patients with LoS > 14 days

Latest month	Jun 23
%	25.2%

Significant deterioration

% Patients with LoS > 21 days

Latest month	Jun 23
%	14.5%

Significant deterioration

Scrutiny to SJR

No. deaths scrutinised by ME - Q5h

Latest month	Jun 23
%	100.0%
Number	543

No significant change

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

Latest month	Jun 23
Number	152

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	Apr 23
%	8.7%

No significant change

Care

Good care identified

In 25 out of 51 cases (49%) good care was identified

Problems with care May-22 to Apr-23

Problem of any other type; Problem in treatment plan; Problem in Clinical Monitoring; Problem with Medication; Problems in relatives communication; Problems in team communication; Problems in Assessment; Problem in IV Fluids; Problem in Resuscitation; Problems leading to readmission; Problem with Infection Control; Problem with Nutrition; Problems in Communication; Problem related to Operation

NCEPOD definitions Jan-23 to Apr-23

Good practice	25
Room for improvement in clinical care	15
Room for improvement in organisational care	3
Room for improvement in clinical and	7
Unable to grade	0
Less than satisfactory	1

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

Latest month	Jun 23
Number	17

No significant change

#N/A

Appendix D: 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
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS2	National Early Warning Score – system for scoring the physiological measurements that are routinely recorded at the patient's bedside