The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 February 2024

Agenda item	019/24			
Report Title	How We Learn from Deaths and Medical Examiner / Bereavement Service Quarter 2 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 Richards, 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, 7th December 2023 Quality Operational Committee, 19th December 2023 Quality & Safety Assurance Committee, 31st January 2024			
Executive summary:	• Timeliness for the issue of the Medical Certificate of Cause of Death improved during Q2 2023-24 but needs to be sustained in the context of winter pressures. • The Trust's SHMI to June 2023, is 98 which is within the expected range. • SJR completion rates are in line with NHSE recommendations and learning used to inform quality improvement initiatives in the Trust. • The invited external expert review requested by SaTH to assist the understanding of the above average neonatal mortality for babies born at the Trust highlighted in MBBRACE reports, including the most recent for deaths in 2021, has been completed. The full report is anticipated in March/April 2024 with recommendations anticipated to be reported in Q4 report. The perinatal mortality review tool continues to be used to identify learning.			
Recommendations for the Board:	The Board is asked to note the report.			
Appendices	Appendix A: Medical Examiner and Bereavement Service Full Report (in Supplementary Information Pack)			

1.0 Introduction

1.1 This paper summarises the key issues pertinent to the Medical Examiner and Bereavement Service and Learning from Deaths programme of work during Q2 2023-24.

1.2 Following the extraordinary report into the increase in deaths within the ED during Q3 2022-23, presented at QSAC 29th November 2023 and written concurrently with this paper, the Learning from Deaths quarter 2 2023-24 report is presented as a Key Issue Update only in part B of this paper. No expanded full report for Learning from Deaths will be available in the Supplementary Information Pack as usual. The Key Issue Update from the Medical Examiner and Bereavement Service available at Part A of this paper is however supported by the full report which is available in the Supplementary Information Pack.

2.0 PART A: MEDICAL EXAMINER AND BEREAVEMENT SERVICE KEY ISSUE UPDATE

2.1 There were 434 deaths across both hospital sites during Q2 recorded by the Bereavement and ME service, which was a reduction of 113 deaths reported in Q1, and a reduction of 71 deaths from the same period in 2022. Approximately 77% of the deaths occurred within the Medicine and Emergency Care (MEC) Division, just under 23% within the Surgery and Cancer Care (SACC) Division and 0.2% within Women and Childrens (W&C) Division. These percentages are in line with previous periods as shown in figures 5-7 in the full report at Appendix A in the Supplementary Information Pack.

2.2 Medical Examiner (ME) scrutiny was provided in 428 of the deaths (98%) that occurred in Q2 2023-24. Those cases that did not receive review are cases directly referred to the coroner but not by the ME service. Of these, 97% of bereaved relatives received a phone call from the ME service to discuss the care, treatment, and cause of death. The cases where contact was not made was due to a combination of no next of kin available and relatives not returning our calls.

2.3 All deaths that are not referred to the coroner should have a medical certificate of cause of death (MCCD) issued within 3 calendar days. Performance against this metric is reported quarterly to the National ME /NHSE. Of the 338 MCCDs written that had no coroner involvement, 84 of these were not completed within 3 calendar days of death, meaning 24% were not issued in accordance with this metric causing delays to relatives registering the death. However this is an improving picture compared to Q1 but focus on this KPI shall remain high as winter pressures increase and the availability of doctors completing death certification becomes challenged once again.

2.4 In Q2 2023-24 there were 35 deaths where the ME recommended an SJR. Further analysis of the reasons for why an SJR was recommended in covered in the full report.

2.5 Despite not receiving confirmation of the legislative changes to allow the statutory system to come into place, the project to extend the ME service to the community continues at pace with progress for working with external stakeholders being made.

2.6 To ensure the service can cope with the additional demand from receiving referrals from across the Integrated Care System (ICS), recruitment of additional MEs has concluded, and there are now 17 MEs doing 18 sessions.

2.7 Approval from the Trust's senior leadership team and the Innovation and Investment Committee (IIC) was granted in support of creating a dedicated bereavement service for

the Trust by appointing two Band 4 Bereavement Officers and a Band 5 Bereavement Supervisor. This supports the plan to release Medical Examiner Officer (MEO) capacity to ensure the ME service is compliant with how the MEOs work in their role, and do not carry out Trust bereavement work. With the IIC giving approval, recruitment of these posts took place throughout Q2, and the successful candidates will join the team during Q3. This is a significant step forward for the Trust in ensuring it provides a robust and supportive bereavement service, but also supports the bigger agenda of developing the ME service to ensure it is ready for the statutory footing.

3.0 PART B: LEARNING FROM DEATHS KEY ISSUE UPDATE

3.1 The Trust's SHMI to June 2023, the latest available data at the time of writing this report, is 98 which is within the expected range. The SHMI is favourable to the CHKS peer group and maintains an improved picture, as it has done even throughout the winter months. Observed deaths are largely comparable to expected deaths for the current time period.

3.2 Acute cerebrovascular disease remains the primary diagnosis condition with the highest number of excess deaths at the Royal Shrewsbury Hospital (PRH) although it is no longer appearing as one of the top three conditions at the Princess Royal Hospital (PRH). An assurance review of 25 patients has been completed with the support of the Stroke Consultants with a primary focus on those patients who died at RSH with a relevant cause of death. The care was deemed to have been appropriate in 24 of the cases with no concerns raised about compliance with the stroke pathway. One patient safety incident datix investigation remains open.

3.3 Additional assurance reviews are currently being undertaken for deaths where the primary diagnosis codes are myocardial infarction, hematologic conditions and those in low mortality condition groups.

3.4 SJR completion rates continue to be above the local target of 30 SJRs per month and the NHSE recommended rate of 15% SJR completion for all deaths has been significantly exceeded for the last 2 months, as seen in charts 1 and 2 below. The high SJR completion rates seen in July and August 2023 reflect the additional senior nurse temporary staffing support for SJRs that was available in that period in addition to the corporate and divisional medical support for SJRs. This temporary staffing availability has now significantly reduced which means that we are no longer able to reliably provide a multi-disciplinary team approach to SJR completion on a regular basis. To maximise learning opportunities a strategy to ensure sustained support from the wider clinical teams needs to be developed or there is a risk that the learning opportunities arising from SJRs may be less impactful.

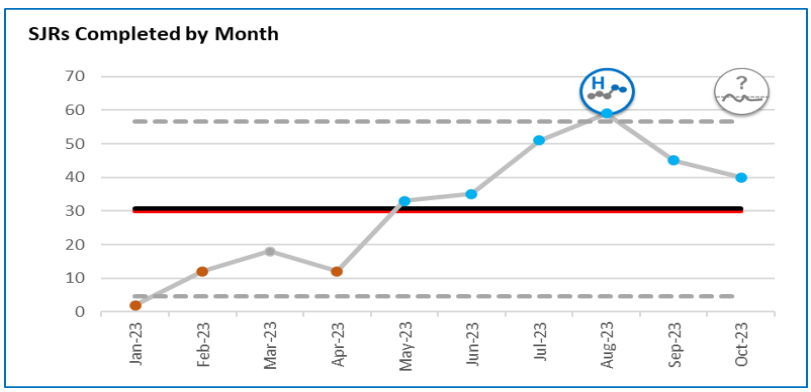

Chart 1: SJR completion by month - variable DoD

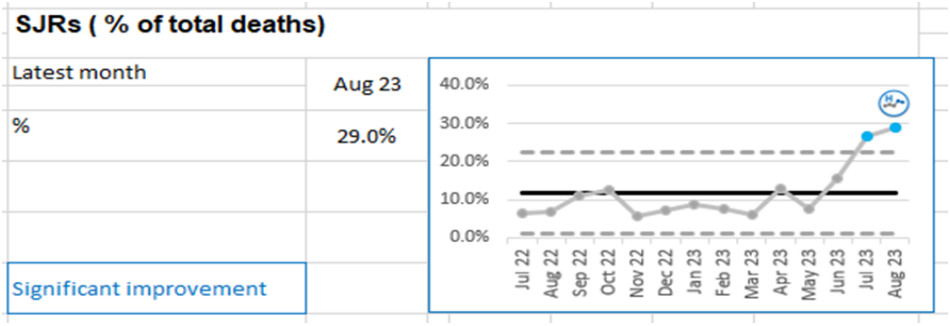

Chart 2: SJR completion as a percentage of total deaths in Trust

3.5 Over 60% of the SJRs completed during Q2 2023-24 identified an overall rating of good or excellent care being provided within the Trust. Learning from excellence is celebrated and promoted through the wider Learning from Deaths agenda including the Trust Learning from Deaths group and Divisional Morbidity and Mortality or Governance meetings. Positive feedback is sent to individual clinicians and clinical teams.

3.6 Out of the 155 SJRs completed during Q2 2023-24, 59 met the criteria for submission of an SJR datix based on identification of an unexpected death, poor / very poor care, Hogan score of preventability greater than 50:50 or above, NCEPOD grading less than satisfactory, any problem in care where potential harm was identified or any case where the reviewer did not feel able to grade the care. An SJR datix is not a patient safety incident datix, although may be converted to this and be reportable to the National Reporting and Learning System (NRLS) once the case has progressed through the Trust Rapid Review forum where level of harm is agreed. At the time of writing this report only 35 out of the 59 SJR datix have been submitted. Work is in progress with the SJR reviewers and the Divisional Quality Governance Teams to ensure any outstanding SJR datix are submitted and to improve monitoring of this process moving forwards.

4.0 Learning to improvement

4.1 Key themes of learning identified through the completion of SJRs as well as the wider learning from deaths processes during Q2 2023-24 relate to:

- Medication issues, including opioid toxicity requiring reversal agent and prescription / administration of drugs to patients where there is a documented allergy. The Learning from Deaths team have worked closely with the Trust Medicines Safety Officer (MSO) regarding these issues. Interim guidance has now been put in place for patients receiving End-of-Life (EoL) care and opiate use, and the MSO is developing a trust wide policy that encompasses not only the use of naloxone but also the use of other reversal agents. A one-minute brief has been released by the MSO to alert staff across the Trust to the use of antibiotics and penicillin allergy. Any further incidences of these issues will be alerted to the MSO to support ongoing quality improvement initiatives.
- Issues regarding timely verification of death. The ME Service and the Palliative and End of Life Care (PEoLC) team have worked collaboratively to produce a handover document to support staff to ensure all required tasks including verification of death have been completed before the deceased patient leaves the ward. A sticker for the notes is being developed to support this.
- Concerns raised by bereaved relatives concerning care on a particular ward within SaTH. This was triangulated with concerns raised through other sources and has led to a focused review and provision of targeted support for this area.
- The accurate completion of fluid balance charts. Any cases noted are referred to the Trust Fluid Balance Specialist Nurse to support the ongoing programme of improvement that is underway.

- EoL issues. These are similar to previous quarters and include completion of EoL plans, use of weekend escalation plans, earlier recognition of the active dying and use of EoL medications. The Learning from Deaths team collaborate closely with the PEoLC team and submit identified learning to them on a regular basis. This is subsequently fed into the system wide steering group and used to inform quality improvement initiatives both within the Trust and the ICS.

5.0 Maternal Mortality

5.1 There have been no direct, indirect or coincidental maternal deaths reported by the Trust within Q2 2023-24.

6.0 Perinatal Mortality

6.1 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) Perinatal Mortality Surveillance Report for Births in 2021 report:

- The latest report for January to December 2021 has now been published.
- Stillbirths and neonatal deaths rose across the UK in 2021 after 7 years of annual reduction.
- The stabilised and adjusted extended perinatal mortality rate (all stillbirths and neonatal deaths) for SaTH is average compared to similar Trusts.

6.2 MBRRACE 2021 SaTH Data: Stillbirths

- There were 12 stillbirths in SaTH during 2021, 10 of which occurred during the antenatal period, 1 during the intrapartum period and 1 was unknown.
- Perinatal Mortality Review Tool (PMRT) was completed for 11 of the 12 stillbirths. One case was rejected by PMRT. In this case, SaTH did not provide antenatal or intrapartum care
- The care in 9 cases was graded as 'B' which means that issues with the care were identified however these did not impact on the outcome.
- The care in 2 cases was graded as 'C' which means that issues with the care were identified which may have made a difference to the outcome.

6.3 MBRRACE 2021 SaTH Data: Neonatal Mortality

- The stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies was 0.89 per 1,000 live births within SaTH. This is more than 5% higher than the average for similar Trusts & Health Boards. Deaths from this year are included in the invited external neonatal mortality review referred to in paragraph 6.4.
- The West Midlands has the highest neonatal and infant mortality rates. Public Health and epidemiological work is ongoing.
- There were 12 neonatal deaths at SaTH during 2021, of which 9 met the criteria for referral to MBRRACE and were included in the report.
- Of the 9 babies who were included in the MBRRACE report:
  - ❑ 8 were early neonatal deaths (< 7 days) and 1 was a late neonatal death (7-28 days).
  - ❑ Congenital anomalies were evident in 3 of the babies (33%).
  - ❑ 5 of the 9 babies were born and died at SaTH
  - ❑ 4 of the 9 babies were transferred to and died at other hospitals.
  - ❑ All of the 9 babies in the MBRRACE report had a Perinatal Mortality Review Tool (PMRT) child death review completed.
- PMRT grading for the 9 babies included within the MBRRACE report:
  - ❑ The neonatal care provided was graded 'B' in 8 of the 9 cases, which means that there were issues with the care identified however these did not impact on the outcome.

- ❑ The neonatal care was graded as 'C' in 1 of the 9 cases which means that care issues were identified which may have made a difference to the outcome.
- ❑ The maternal care was graded as 'C' in 2 of the 9 cases.
- ❑ All identified actions for improvements in the 3 cases graded as 'C' have been completed and Quality Improvement (QI) projects are in progress.

- PMRT was also completed for the 3 neonatal deaths which did not meet the inclusion criteria for MBRRACE.

6.4 The invited external expert review in relation to the above average mortality within SaTH highlighted in the latest MBBRACE report has been completed. It is anticipated that the recommendations identified from the review will be presented within the Q4 2023-24 iteration of this paper.

7.0 Paediatric mortality

7.1 During Q2 2022-23, 6 paediatric deaths have been managed by the Medical Examiner Service. Of these, 5 occurred in the Emergency Department (ED) and 1 occurred as an inpatient on the paediatric ward with an advanced care plan in place. All of these deaths will be reviewed through the Child Death Overview Panel (CDOP) process. No serious incidents have been reported for any of these cases.

7.2 National Child Mortality Database (NCDM): Following the latest release of data from the NCDM detailing child deaths 0-17 years up to 31 March 2023, it has been identified that infant deaths across the West Midlands, for all localities including Shropshire, Telford and Wrekin (STW), is higher than other regions combined, and increasing (regionally and nationally).

7.3 Death rates for Infants and children aged 1-17 years are disproportionately high, locally, regionally and nationally, in the most deprived quintile and in Black and Asian populations, and rates have increased in the past 3 years. Death rates for children aged 1-17 years has increased regionally and across the whole of the United Kingdom in the past 3 years, and for all age bands 1-4, 5-9, 10-14 and 15-17 years.

7.4 Data completion and the timeliness of STW CDOP reviews is the highest across the West Midlands region despite limited resources.

7.5 There were 18 deaths of children aged 1-17 years across the whole of STW between 1st April 2022 and 31st March 2023, an increase of 7 from the previous year and 13 from 2019-20. Serious Incident (SI) investigations were commissioned for 3 of these cases, where the child had died as an inpatient within the Trust. Common themes relating to care of the deteriorating child were identified which has informed wider quality improvement work within the division.

8.0 Deaths deemed more likely than not due to problems in healthcare

8.1 During Q2 2023-24, there have been no serious incident investigations presented to RALIG where outcome determined that the death was deemed more likely than not due to problems in healthcare.

9.0 Deaths of patients with a confirmed Learning Disability, Autism or a Serious Mental Illness

9.1 In Q2 2023-24 there were 2 patients with confirmed learning disabilities or autism reported to LeDeR, who died in the Trust, either as an inpatient or in the emergency

department. The SJR has been completed for one of these patients and the other case has been reported as a serious incident, the investigation of which will replace the SJR.

9.3 The provision of specialist support for SJRs mandated for patients who die in the Trust with a confirmed learning disability or autism remains unresolved. However, 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.

9.2 In Q2 2023-24, there were 2 deaths of patients with a serious mental illness (SMI) of which 1 SJR has been completed. At the time of writing this report,1 SJR for a patient who died in Q4 2022-23 and 1 SJR for a patient who died in Q1 2023-24 with an SMI, remain outstanding. These are being supported by the Mental Health Clinical Nurse Specialist in the Trust.

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

10.1 The collaborative review undertaken to review the increase in deaths within the ED during Q3 2022-23 has been concluded and the final report was presented to the Quality and Safety Assurance Committee on the 29th of November 2023, with presentation to the Board of Directors anticipated on the 14th of December 2023.

10.2 A summary of the findings is provided below:

- The review of increased deaths within the EDs in Q3 22-23 did not identify any significant lack of medical or nursing care that resulted in an increased mortality rate in the ED during Q3 2022-23.
- The increased deaths within ED are likely to have been in part related to the increased length of stay within the ED.
- Internal professional standards in respect of clinical team assessment are regularly breached because of workload.
- The incidence of out of hospital cardiac arrests increased in this period, which is unexplained.
- There is published evidence that morbidity and mortality increases in older patients who have to wait overnight or for long periods of time in the ED for a ward bed.
- The increase in deaths within ED at SaTH during Q3 2022-23 is representative of the national picture albeit the increase is greater.
- Learning has been identified in respect of documentation by clinical teams whilst patients are boarded in the ED.

10.3 Since the number of deaths that occurred within the ED increased within Q3 and extending into Q4 2022-23, there has been a steady decrease in line with seasonal variance. This will continue to be monitored through the Learning from Deaths and Medical Examiner Dashboards, which are presented as a monthly standing agenda item on the Trust Learning from Deaths group.

11.0 Patient Safety Incident Response Framework (PSIRF)

11.1 The new PSIRF will be introduced across the Trust on the 1st of December 2023. The Learning from Deaths team have worked collaboratively with the Patient Safety Specialists to ensure that the Learning from Deaths agenda is appropriately incorporated

into this new framework and will continue to collaborate closely to support this following implementation.

12.0 Risk Register

12.1 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 is fully appointed to. Plans have now been established to relocate the Learning from Deaths team which are currently subject to financial approval for refurbishment costs required.

13.0 Recommendation(s)

13.1 The Board is asked to note the issues highlighted in this report and the progress made within Q2 2023-24.

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Dr Suresh Ramadoss, Lead Medical Examiner
Lindsay Barker, Medical Examiner and Bereavement Service Manager
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