Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Trust Board of Directors

Held on 25 January 2022

Subject	Learning from Deaths Report – Q1 2021/22 (1st April – 30th June 2021)
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Status[1]	N

PURPOSE OF THE REPORT

This is the quarterly report to the Trust Board of Directors on the deaths of patients under the care of Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), as required by the Learning from Deaths Guidance dated March 2017. This report covers Q1 of 2021/22 (1st April – 30th June 2021).

KEY POINTS

The Learning from Deaths Report considers deaths at STHFT in the period 1st April – 30th June 2021 as follows:

- Total no. deaths at STHFT: 574 (566 + 8 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR): 47 (39 + 8 neonatal)
- Of the deaths subject to SJR, the number of deaths judged more likely than not to be due to a problem in care: 0

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Trust Board of Directors is requested to note the content of the report in the context of the COVID-19 pandemic.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	12th January 2022	Y
Healthcare Governance Committee	17th January 2022	Y
Trust Board of Directors	25th January 2022	

[1]Status: A = Approval, A* = Approval & Requiring Board Approval, D = Debate, N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Learning from Deaths Report

Q1 2021/22 (1st April – 30th June 2021)

1. Introduction

This is the quarterly report to the Trust Board of Directors on deaths of patients under the care of STHFT as required by the National Guidance on Learning from Deaths (March 2017). The data are reported as agreed internally with the Trust Executive Group i.e. all deaths will be included six months from the end of a quarter, except HM Coroner referrals that are still in progress and will be reported at a later date.

The Structured Judgement Review (SJR) is a validated standardised method which scores the overall care given to deceased patients on a scale of one to five. It is the nationally accepted tool for the review of adult deaths in acute hospital care in England. Scores of one or two are low scores and are described as 'very poor' or 'poor' care respectively. Any case which receives a score of one or two from the SJR is further investigated to determine if the death was more likely than not due to a problem in care. Across all scores there are valuable learning opportunities for the organisation.

2. STHFT Medical Examiner System

During Q1 of 2021-22 the 1.8 whole time equivalent Medical Examiner Officer (MEO) staffing was a shortfall from the recommended 2.9 whole time equivalents (WTE) advised by NHS England and NHS Improvement for a Trust with approximately 2,900 deaths. Recruitment of an additional 1.0 WTE MEO was completed in March 2021 (with a commencement date of July 2021). This report covers a period of optimal Medical Examiner ME staffing (1.05 WTE which includes 0.08 WTE to administer the SJR process).

Table 1 presents the number of adult deaths and reviews at STHFT during the period 1st April – 30th June 2021. During this quarter, there has been reduction in the number of deaths (566) compared to Q1 in previous years (733 in 2020/21, 672 in 2019/20, 650 in 2018/19 and 667 in 2017/18). 566/566 (100%) received a ME review.

3. Learning from Deaths Cases Reviewed

Eight neonatal deaths have been subject to a separate, established mortality review process in the Jessop Wing which, for the purposes of this report, will be referred to as SJR. Information on neonatal review in Q1 2021/22 is included in a separate report quarterly to the Trust Executive Group.

39 of 566 (6.9%) adult and eight of eight (100%) neonatal deaths occurring in Q1 have been subject to SJR (Table 1). One adult case is still awaiting a first review due to the availability of case notes and one is awaiting arbitration to agree the final overall score.

Although the pressures of COVID-19 had impacted the capacity of the SJR Expert Group over previous quarters, a plan put in place in October 2021 has addressed the backlog of cases.

Table 1: Quarterly breakdown of adult reviews

	1st Apr – 30th Jun 2021 (Q1)
Total number of adult deaths at STHFT	566
No. of adult deaths subject to an ME review	566
No. SJRs completed	39
No. SJRs score <3 (poor care)	1
Of the deaths subject to SJR, no. deaths judged more likely than not to be due to a problem in care	0

Table 2 shows the number of adult cases within the mandatory categories of referrals for SJR (41). 39 SJR's were completed, one is awaiting first review and one is awaiting arbitration.

Table 2: Mandatory categories of SJR referrals

	1st Apr – 30th Jun 2021 (Q1)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	0
Learning disabilities or with severe mental illness	15
Learning will inform the provider's existing or planned improvement work	8
Not expected to die (e.g. in relevant elective procedures)	15
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. COVID-19	3
Total referrals	**41**

In this quarter, 88 adult cases were notified to the coroner after scrutiny by a ME and taken for investigation. It should be noted that there are many statutory reasons to refer a case for coronial inquiry which are often not related to concerns about care.

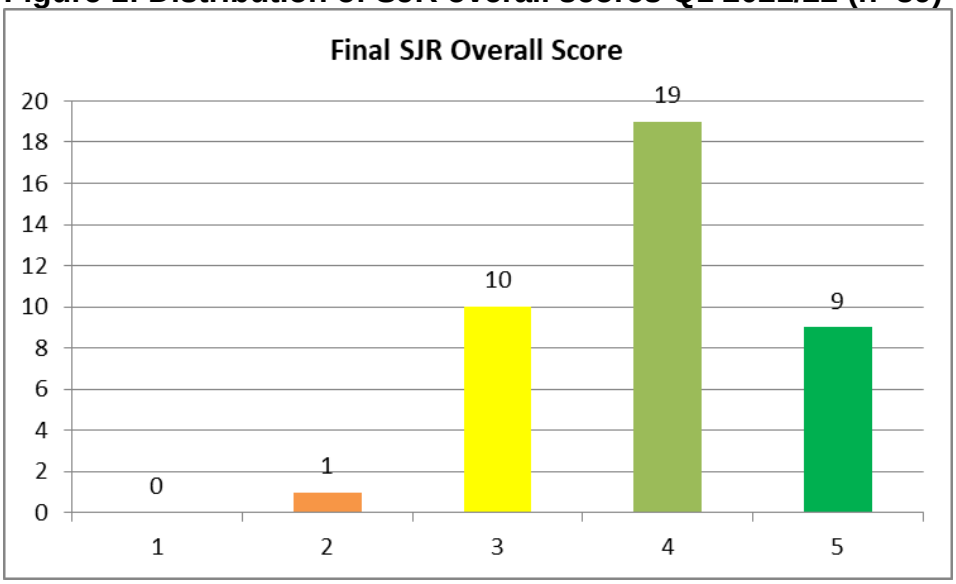
Of the 39 completed adult SJR cases, eight were deaths of patients with a learning disability and seven were deaths of patients with a serious mental illness. All 15 cases scored three or greater (good care). No cases relating to patients with learning disabilities or severe mental illness are still awaiting a first review. Of the deaths subject to SJR during this period (39), the number of deaths judged more likely than not to be due to a problem in care is zero.

4. Distribution of Scores

Of the 39 adult SJRs completed, one (2.6%) had a score of less than three, which remained at that level when subject to a second review. This case has been referred back to the directorate for a response, including relevant clinical context, and will be discussed in the Mortality Governance Committee (MGC).

Figure 1 shows the distribution of SJR overall scores for the 35 completed SJRs.

Figure 1: Distribution of SJR overall scores Q1 2021/22 (n=39)



5. Cases Scoring Less than Three in Previous Quarters

Five cases in the previous quarter and one case in the current quarter scored less than 3 with an overall outcome of 'poor care'. The key learning from these cases is described in section 6.

6. Learning and Actions from SJR scores less than three

a) Fluid balance and monitoring - scheduled as Trust 'Safety Message of the Month' and local directorate education plan in place

b) DNACPR awareness and communication – a Trustwide audit has been undertaken to review the completion of DNACPR forms and the recording of discussions in patient case records with the report and risk assessment planned for discussion at Clinical Effectiveness Committee in February 2022. The results will be shared with the Mortality Governance Committee and the End of Life Care Steering Group. The Directorate is planning to trial inclusion of DNACPR as part of morning board round discussions.

c) Admission pathways – the Medicine Forum has reviewed and updated the Standard Operating Procedure for direct emergency admissions, which has been approved by the Mortality Governance Committee to ensure that patients admitted directly to the ward are identified as requiring consultant review on the post-take ward round.

7. Serious Incident Actions

Four adult deaths were reported as Serious Incidents in this reporting quarter:

- A patient had unwitnessed falls resulting in acute bilateral subdural haematomas with subarachnoid haemorrhage and death. This case was linked to two complaints, an inquest and a claim, and is awaiting an SJR review (delayed due to lack of availability of case notes).
- A patient with abdominal aortic injury arising from spinal surgery, which was linked to a complaint and an inquest.
- A patient with delayed treatment of diabetic ketoacidosis.
- A patient referred by their GP who had a delayed medical assessment, which was linked to an inquest and a claim.

8. Deaths more likely than not due to a problem in care

No cases during Q1 of 2021/22 were judged to be more likely than not due to a problem in care.

9. Regulation 28 Notifications and Prevention of Future Deaths

There were no Regulation 28 Notifications from the outcomes of Coroner Inquests in this quarter.