Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 28 April 2020

Subject:	Learning From Deaths Report – Q2 (1st July - 30th September 2019)
Supporting Director:	Dr Jennifer Hill, Medical Director, Operations
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Status[1]	A*

PURPOSE OF THE REPORT

This is the quarterly report to the 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 of March 2017. This report covers Q2 of the 2019-20 period (1st July 2019 – 30th September 2019).
Since April 2017, acute hospital trusts have been required to collect and publish specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter, to set out publication of the data and learning points. The data should include the total number of in-patient deaths (including Emergency Department deaths for acute trusts) and those deaths that have been subjected to case record review. Of the deaths subjected to case record review, trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

KEY POINTS

The Learning from Deaths Report considers deaths at STHFT in the period 1st July 2019 – 30th September 2019 as follows;

- Total deaths at STHFT 617 (including 7 neonatal)
- Total deaths subject to Structured Judgment Review 65 (including 7 neonatal)
- N° deaths judged more likely than not to be due to a problem in care 0

The Trust's Structured Judgment Review Group has been in place since September 2018.

IMPLICATIONS[2]

AIM OF THE STHFT CORPORATE STRATEGY 2017-2020		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	

RECOMMENDATIONS

The Board of Directors is requested to discuss the findings and to contribute to the on-going development of this report and the learning it aims to promote.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	15th April 2020	Y
Healthcare Governance Committee	20th April 2020	Y

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

[2] Against the five aims of the STHFT Corporate Strategy 2017-20

Learning from Deaths Report
Q2 2019/20 (1st July 2019 – 30th September 2019**)**

1. Introduction

This report is the quarterly report to the 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.

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 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

For the past ten years, the Trust has benefitted from a well-established Medical Examiner System (MES) based at the Northern General Hospital (NGH) site, established as part of a national pilot project that ended in March 2019. The pilot phase of this work lasted almost a decade and during this time STHFT was able to establish a system which scrutinised approximately 85% of deaths at STHFT. The lead ME was subsequently recruited to a national role and ceased to deliver the ME function at STHFT in May 2019. This significantly reduced the Trust's ME capacity.

From April 2019 the ME- led system began roll out within hospitals in England and Wales as a non-statutory system whereby all deaths will be subject to either a ME's scrutiny or a coroner's investigation following full implementation. The implementation of the national ME system in this non-statutory phase has been suspended during the COVID-19 pandemic. The numbers of cases subject to scrutiny within both the MES and LfD process during this time will be reduced as the clinicians who conduct the ME work and the SJR work are utilised in delivering their primary clinical functions.

The Trust is pursuing active recruitment to the additional ME roles required to cover all deaths so that, where it is feasible, work can begin on the training aspects of their roles. Once the non-statutory phase has ended, the plan is that 100% of deaths occurring across the Trust have a ME review and that the mandatory cases, along with a selection of further cases, have an SJR.

3. Learning from Deaths data

Table 1 presents deaths at STHFT during the period 1st July 2019 – 30th September 2019.

Table 1: Quarterly breakdown of adult reviews

	1st July 2019 – 30th September 2019 (Q2)
Total N° deaths STHFT	617
N° deaths subject to a ME review	145
N° SJRs	58
N° 'Poor' SJR scores (1 or 2)	5
N° deaths judged more likely than not to be due to a problem in care	0

Table 2 provides the quarterly breakdown of neonatal reviews and in future reports information on all perinatal deaths will also be included. Seven neonatal deaths were 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.

These seven deaths were referred for SJR and all cases have been reviewed. A neonatal death has been defined as per MBRRACE reports (Live birth at 23 weeks of pregnancy or greater) and includes deaths that occurred at STHFT or deaths that followed planned palliative care and death occurred at home or in a hospice.

Table 2: Quarterly breakdown of neonatal reviews

	1st July 2019 – 30th September 2019 (Q2)
Total N° neonatal deaths at STH	7
N° referred for SJR	7
N° of SJR's (or equivalent) carried out	7

From Tables 1 and 2 it can be seen that during the period 1st July – 30th September 2019, a total of 65 deaths were subject to a SJR or the neonatal equivalent (58 adult +7 neonatal). Four further cases identified for SJR are awaiting first review and have been delayed due to issues related to case note availability / allocation and reviewer capacity. These cases will continue to be followed up.

There are no SJR cases to date where a death has been judged more likely than not to be due to a problem in care.

214 cases were referred to Her Majesty's Coroner (HMC) by the MES. It should be noted that the reasons for coroner investigation are many, often unrelated to possible problems in care.

Of the 62 adult cases referred for SJR, one was a death of a patient with a learning disability and four were deaths of patients with serious mental illness. A SJR has been completed for all five cases and all scored 'good' or 'excellent' care.

Table 3 shows the number of cases within the mandatory categories of referrals for SJR.

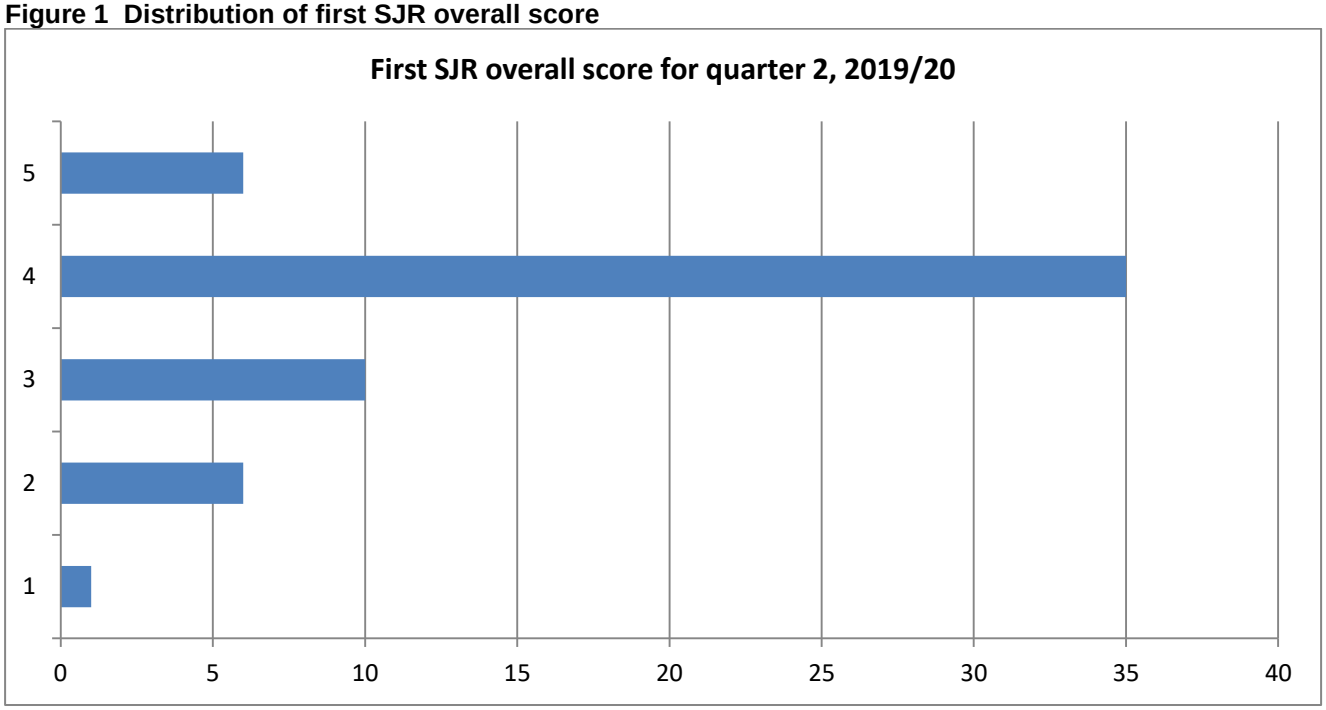
Table 3: Mandatory categories of SJR referrals

	1st July 2019 – 30th September 2019 (Q2)
Bereaved families and carers, or staff, have raised a significant concern about the quality of care provision	2
Learning disabilities or with severe mental illness	5
Service speciality, particular diagnosis or treatment group where an 'alarm' has been raised	0
Not expected to die (e.g. elective procedures)	14
Learning will inform the provider's existing or planned improvement work	41
Total Referrals	**62**

4. Distribution of scores

Of the seven initial SJRs scoring two or below, all seven had a second review and two of the seven had a score change to 3, 'adequate', following second review and arbitration.

Figure 1 Distribution of first SJR overall score



5. Learning from mortality analysis

The Learning from Deaths Facilitator co-ordinates all aspects of the process including ensuring SJR cases are allocated to reviewers appropriately, case notes are made available to reviewers in a timely way, and reviews are completed and entered via the Datix platform. The Facilitator also acts as the SJR database manager, dealing with routine and ad-hoc queries and assists with analysis of the data collected to identify learning.

a) Serious Incident Actions

A total of two deaths in this reporting quarter had associated serious incidents reported to the CCG. Both of these investigations have been completed and identified learning including opportunities for

improved communication methods relating to patients at high risk of falling, and opportunities to improve documentation for procedures undertaken in ambulatory care rooms.

b) **Actions arising from 'poor' SJRs**

Following second review, a total of five SJR cases were rated as 'poor' overall care during this quarter. Directorate context and action plans have been requested for all five cases prior to review at the Mortality Governance Committee (MGC). One directorate response is currently scheduled for review by the MGC with further work being carried out on the remaining four cases which will be scheduled for MGC review once completed. So far none of the five cases have been escalated as a serious incident.

c) Thematic analysis of SJR comments: 'End of life care'

Work is on-going with thematic analysis of SJR reviewer comments. So far all comments from reviews in the SJR Database where 'End of life care' was scored 'poor' by two independent reviewers have been themed.

This qualitative analysis is comprised from 133 individual comments extracted from 19 separate SJRs. In addition to 22 'positive' and 70 'negative' comments, there are also 26 'neutral' comments and 15 'repeat' comments. An explanation of the different high level themes and exclusions can be found in Appendix 1. As expected, due to the criteria for selecting these cases for analysis, the 'negative' comment count is higher than the 'positive' comment count. The thematic break down of the 'positive' and 'negative' comments is presented in Figure 2 and Figure 3 respectively.

Figure 2 Thematic breakdown of positive comments

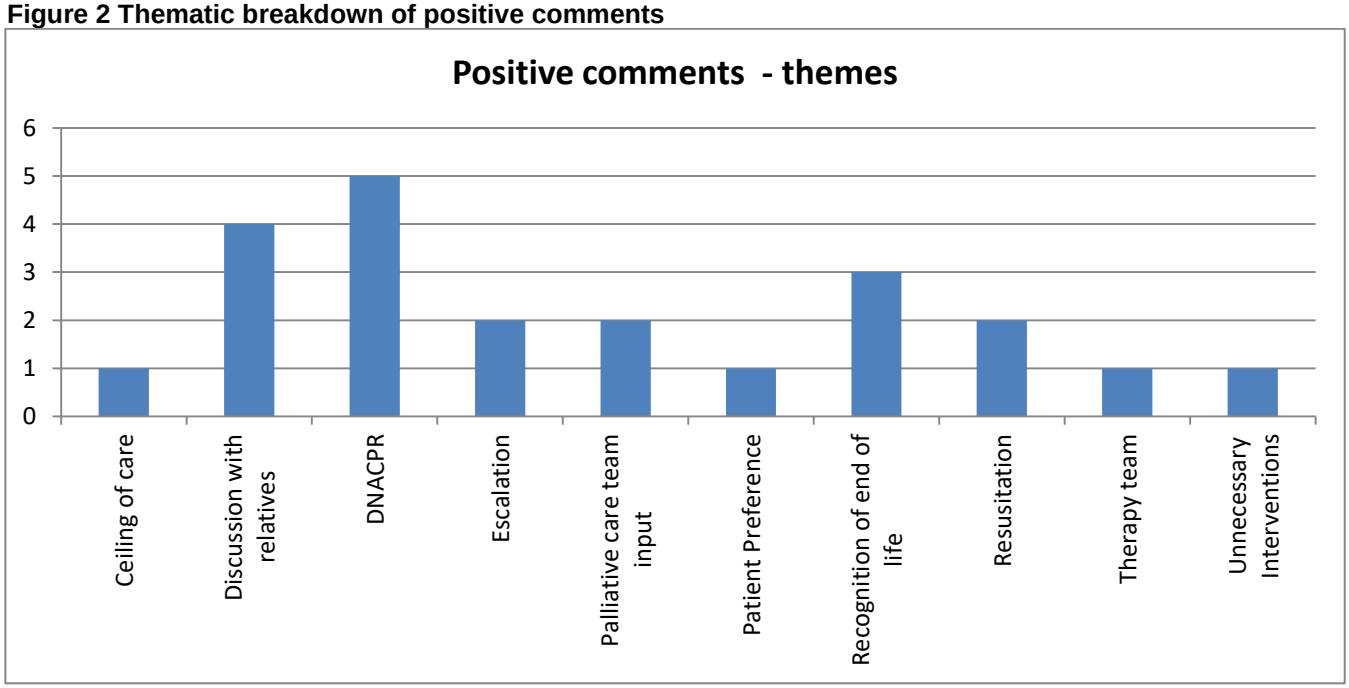
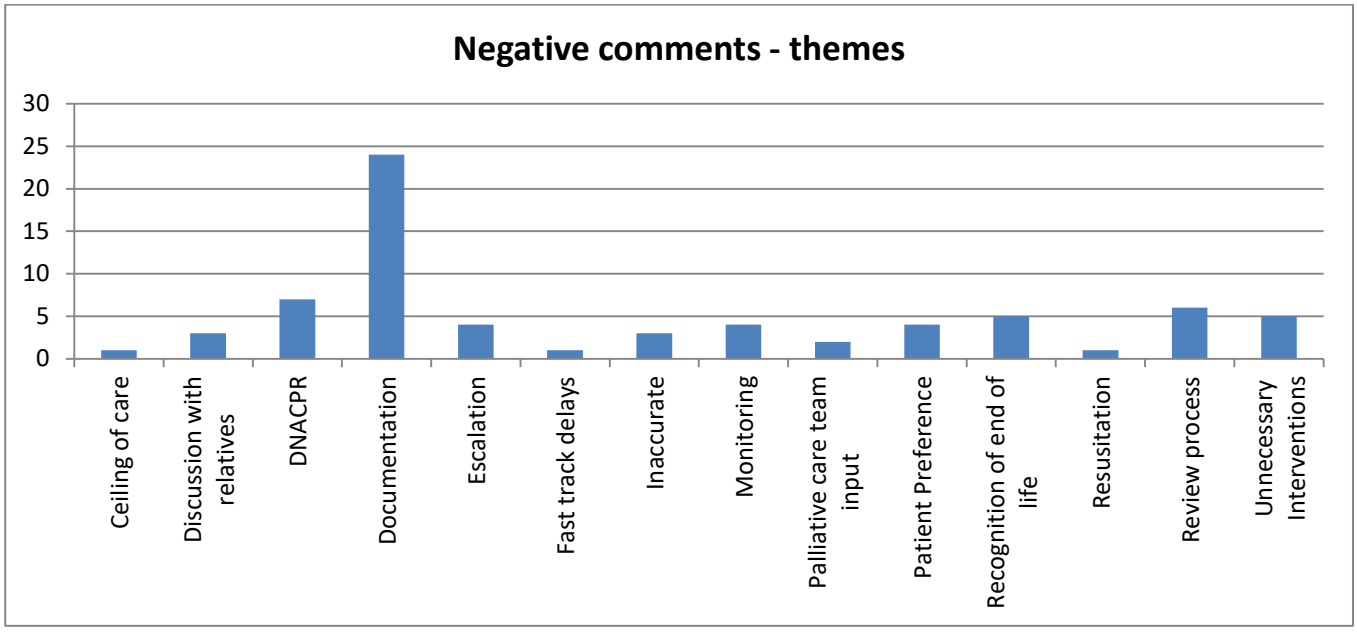


Figure 3 Thematic breakdown of negative comments



5 Summary

The SJR reviewer comments from these themes have been analysed and will inform the on-going work of the End of Life Care Steering Group. Key areas for attention include;

- DNACPR
- Documentation
- Recognition of ‘End of life’

SJR analysis: high-level themes and exclusions

‘**Positive**’ comments – these are statements made by a reviewer that explicitly or implicitly state good care was given in the context of the review.

‘**Negative**’ comments – these are statements made by a reviewer that explicitly or implicitly state poor care was given in the context of the review.

‘**Neutral**’ comments – these statements are interpreted as having no positive or negative implications so no learning can be drawn. These comments are not included for analysis.

‘**Repeat**’ comments – these are positive or negative comments when both reviewers have commented on the same aspect of care in a case. They are excluded from count analysis so as not to emphasise a particular concern out of proportion.