Sheffield Teaching Hospitals NHS
NHS Foundation Trust

EXECUTIVE SUMMARY

REPORT TO THE TRUST BOARD OF DIRECTORS

HELD ON 26 JANUARY 2020

Subject:	Learning From Deaths Report – Q1 (1st April – 30th June 2020)
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Status[1]	A*

PURPOSE OF THE REPORT:

This report 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 of March 2017. This report covers Q1 of 2020/21 (1st April – 30th June 2020).

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 inpatient 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 April – 30th June 2020 as follows:

- Total no. deaths at STHFT — 733 (729 + 4 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR) — 46 (42 + 4 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:

	Aim of the STH Corporate Strategy 2017-2020	**Tick as Appropriate**
1	Deliver the best clinical outcomes	✓
2	Provide Patient Centred Care	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATION(S):

The 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	13th January 2021	Y
Healthcare Governance Committee	18th January 2021	Y
Trust Board of Directors	26th January 2021	

[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

*Data source: Bereavement Database & Neonatology Mortality Lead

Learning from Deaths Report

Q1 2020/21 (1st April – 30th June 2020)

1. Introduction

This report 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.

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

2. STHFT Medical Examiner System

The Trust has had a total of 10.5PAs of ME time (1.1 whole time equivalents) in place since 1st July 2020 and as of *1st June 2020*, 100 per cent of deaths occurring at the NGH and the RHH sites have a ME review (Table 2) and the mandatory cases, along with a selection of further cases, have a SJR.

Appointment to a third MEO post in November 2020 has coincided with the departure of the Lead MEO and hence the current 1.8 whole time equivalent staffing is still a shortfall from the recommended 2.9 whole time equivalents advised by NHS England and NHS Improvement for a Trust with approximately 2900 deaths. The Lead MEO post is in the active recruitment phase.

This report covers the period prior to the increase in ME staffing and includes the first wave of the COVID-19 pandemic when the availability of ME's and reviewers was reduced. In addition the publication of national guidance advised standing down MES's during the pandemic if they were needed more urgently elsewhere. As a result of these issues fewer ME reviews were performed and fewer SJRs were undertaken. It is possible that this position may be replicated in future quarters impacted by the COVID-19 pandemic.

3. Learning from Deaths cases reviewed

Table 1 provides the quarterly breakdown of neonatal reviews in Q1 2020/21. All four 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. The term 'neonatal death' now includes live births greater than 22 weeks gestation, as there is new national guidance about resuscitation at this gestation, and includes deaths that occurred at STHFT or deaths that followed planned palliative care where death occurred at home or in a hospice.

Table 1: Quarterly breakdown of neonatal reviews

	1st April – 30th June 2020 (Q1)
Total no. neonatal deaths at STHFT	4
No. referred for SJR equivalent	4
No. SJR equivalent carried out	4

Table 2 presents the number of adult deaths and reviews at STHFT during the period 1st April – 30th June 2020. Due to the COVID-19 pandemic there have been fewer admissions for non-COVID related activity during this period than usual. However, there have been more deaths than those reported in the Q1 Report 2019/20 (672) and 448/729 (61%) have received a ME review. This was an improvement over the Q4 2019/20 figure of 28% when the previous Lead Medical Examiner Officer was being recruited (February 2020).

Table 2: Quarterly breakdown of adult reviews

	1st April – 30th June 2020 (Q1)
Total no. adult deaths at STHFT	729*
No. deaths subject to a ME review	448
No. SJRs completed	42
No. SJRs score <3 (poor care)	2
Of the deaths subject to SJR, no. deaths judged more likely than not to be due to a problem in care	0

*Identified via Information Services Report

From Tables 1 and 2 it can be seen that during the Q1, a total of 42 adult and four neonatal deaths were subject to SJR (6.0%). An additional 25 adult cases are awaiting a first review.

There has been a delay in carrying out SJRs due to the impact of COVID-19 and losing experienced Expert Reviewers to ME posts in Q1. Two adult cases from Q4 2019/20 have received a second review and the score has remained the same. Directorate responses have been requested for both cases and will be referred to the Mortality Governance Committee for further scrutiny.

Table 3 shows the number of cases within the mandatory categories of referrals for SJR. Cases in the category 'not expected to die' were identified from a combination of ME referrals and hospital elective deaths data to ensure appropriate cases for SJR would not be missed (though not all deaths following elective admissions fall into this category). This has resulted in more cases in this category than we have seen in previous quarters where ME referral alone was the determinant. Processes were also agreed with the Trust LeDeR Lead to ensure that all learning disabilities patients were identified. Due to the pressures of COVID-19, the capacity of the SJR Expert Group at the end of Q1 and availability of case records have been limiting factors for the number of SJRs carried out. However, six new reviewers have been appointed at the end of 2020 and will start immediately to address the backlog of cases.

Table 1: Mandatory categories of SJR referrals

	1st April – 30th June 2020 (Q1)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	6
Learning disabilities or with severe mental illness	17
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. Covid-19	17
Not expected to die (e.g. some elective procedures)	15
Learning will inform the provider's existing or planned improvement work	12
Total referrals	**67**

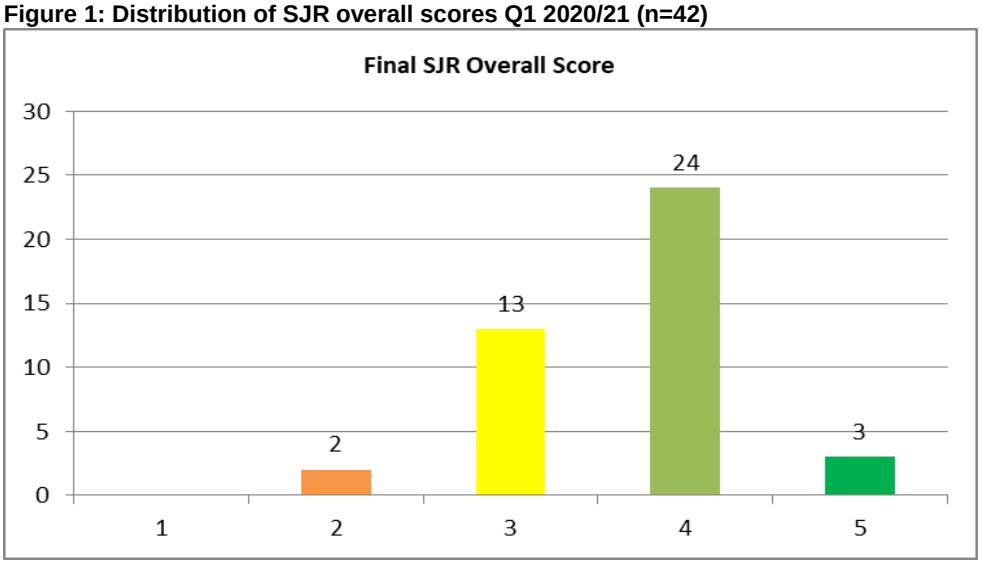
Seven of the 15 cases from the 'not expected to die' category shown in Table 3 are awaiting allocation due to the availability of casenotes, two have been allocated and are awaiting first review and six have been completed with scores of three or greater. 58 cases were referred to HM Coroner (HMC) by the MES, much lower than in previous quarters (i.e. in Q4 of 2019/20 there were 248 coroner referrals). It should be noted that the reasons for Coroner investigation are many, and are often not related to concerns about care.

Of the 42 completed adult SJR cases, six were deaths of patients with a learning disability and five were the deaths of patients with serious mental illnesses. Ten of these 11 cases scored three or greater (good care) and one scored less than three. Three learning disabilities and three mental illness cases are still awaiting a first review. Of the deaths subject to SJR during this period, 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 42 adult SJRs completed, two (5%) had a score of less than three. These cases received a second review, with the score remaining less than three. Figure 1 shows the distribution of SJR overall scores for the 42 completed SJRs. 64% scored four or five.

Figure 1: Distribution of SJR overall scores Q1 2020/21 (n=42)



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, casenotes 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) Actions arising from 'poor' SJRs

For the two cases following second review that were rated as 'poor care' overall, directorate context and action plans have been requested prior to review at the Mortality Governance Committee. Due to COVID-19 clinical pressures, there has been a delay in receiving directorate responses. There are no related incidents, complaints or inquests for these cases.

b) Serious Incident Actions

No deaths in this reporting quarter were reported as an Internal Serious Incident.

c) Regulation 28 Notifications

No deaths in this reporting quarter received a Regulation 28 Notification from the Coroner.

d) Learning and Feedback on the SJR Process

Further to feedback received from Directorates and clinical teams, a SJR Dashboard has been developed, which allows relevant individuals to run queries and reports locally. This includes a full listing where all SJRs on the database can be filtered and charts automated to quickly view scores, current status, referral criteria and much more. Additional functions have also been added to enable the Emergency Care Group to see all cases which were emergency admissions and OSCCA can see if they had any involvement in care, even where they were not necessarily the parent specialty. Feedback to date has been positive and this will be developed further as required.

e) Themes identified by SJR and Mortality Governance Committee

Mortality Governance Committee responsibility now includes a full review of SJR cases scoring less than three, along with directorate context, feedback and action plans. Emerging themes for improvement are fed back to directorates and include:

- Timeliness of verification of death – the verification of death is often recorded a few hours later than the actual time of death, and sometimes on a different date (if the patient has died at night and the verification of death has been completed the next morning). This can cause distress to bereaved families where the dates/times differ.
- Attempted resuscitation when a DNACPR order is in place continues to be identified in SJR reviews and across the whole of the Trust

f) Review of Directorate Morbidity and Mortality Meetings

A review of Directorate Morbidity and Mortality (M&M) Meetings has been undertaken in response to the 360 Assurance Learning from Deaths Audit Report issued in November 2019. This has been registered with the Clinical Effectiveness Unit, completed, and is scheduled for review at the January 2021 by the Mortality Governance Committee (delayed due to impact of COVID-19 pandemic). As M&M meeting frequency is determined by directorate governance teams locally, the review will feed into the action to introduce standardisation of learning from deaths feedback to the Mortality Governance Committee from directorates, which in turn will support the implementation and dissemination of active learning from the process.

g) Learning from Deaths Risk Assessment

A risk assessment for the Learning from Deaths process has been undertaken as recommended in the 360 Assurance Learning from Deaths Audit Report (November 2019). This has been added to the Trust Risk Register and will be monitored by the Mortality Governance Committee.

h) Learning from Deaths Newsletter

A ‘Learning from Deaths Update’ newsletter has been produced and circulated throughout the Trust in December 2020. This included information on the SJR process and scores, Medical Examiner Service, Regulation 28s issued by HM Coroner, learning from deaths in Integrated Geriatric and Stroke Medicine and actions being taken to improve the process, based on feedback from directorates. This will become a quarterly newsletter to improve Trustwide communication relating to mortality and learning from deaths.