SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Executive Summary

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Report to the Board of Directors

Held on Tuesday 29th October 2019

Subject	Learning From Deaths – Q4 2018/19
Supporting TEG Member	David Hughes, Medical Director
Author	Paul Whiting, Associate Medical Director Janet Brain, Senior Manager Clinical Effectiveness & Patient Experience Rachel Smith, Learning from Deaths Facilitator on behalf of Mortality Governance Committee
Status[1]	A*

PURPOSE OF THE REPORT

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 Learning from Deaths Guidance, March 2017. This report and covers the period 1st January 2019 to 31st March 2019.

From April 2017, 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 the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has 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 to the Board of Directors considers all deaths at STHFT in scope. The results for Sheffield Teaching Hospitals NHSFT 1st January 2019 to 31st March 2019 are as follows,

- Total deaths at Sheffield Teaching Hospitals NHSFT 791 (2 neonatal deaths)
- Total deaths subject to a Medical Examiner review 538
- Total deaths subject to Structured Judgment Review 87 (plus 2 neonatal reviews)
- Deaths referred to the coroner 208

The Trust Expert Structured Judgment Review (SJR) Group has been in place since 17/09/2018

IMPLICATIONS

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 Trust Board of Directors is requested to approve the Quarter 4 2018/19 Learning from Deaths report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	9th October 2019	Y
Healthcare Governance Committee	21st October 2019	Y
Trust Board	29th October 2019	

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

[2] Against the five aims of the STHFT Corporate Strategy 2017-2020

Learning from Deaths Report
Q4 2018/19 (1st January – 31st March 2019)

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 covering the period 1st January 2019 to 31st March 2019 and reports in line with Trust requirements i.e. all closed work, except HM Coroner referrals, which is in effect six months from the end of the previous quarter.

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. The scores of one or two are low scores and are described as very poor or poor care respectively. Any case which receives such a score from the SJR is further investigated to determine if the death was more than likely than not due to a problem in care.

Where there are no cases that have been identified as judged more likely than not to be due to a problem in care, the systematic and robust SJR methodology still provides valuable opportunities to the organisation for learning from reviews. Annex 1 of the Learning from Deaths Guidance requires that the trust board 'ensures that learning from reviews is acted on to sustainably change clinical and organisational practice and improve care' and 'shares relevant learning across the organisation and with other services where the insight gained could be useful'.

Purpose of the report

From April 2017, 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 for each quarter to set out publication of the data and learning points. The data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has 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. This summary report covers 1st January 2019 to 31st March 2019.

The following table considers all deaths at STHFT in scope:

- All deaths subject to a Medical Examiner System (MES) Review [a]
- All deaths subject to a SJR [b]
- All deaths judged more likely than not to be due to a problem in our care

Key Findings

Table 1: Quarterly breakdown of adult reviews

	1st January 2019 to 31st March 2019 (Q4)
Total N^{o} deaths STH	791
N^{o} deaths NGH	616
N^{o} deaths subject to a MES review[a]	**538**
N^{o} deaths referred to HM Coroner	**208**
N^{o} deaths referred by MES for SJR (or picked up via triangulation)	**91**
N^{o} SJRs - first review[b]	**87**
(as a percentage of SJRs requested)	*96%*
N^{o} 'Good' SJR scores(3, 4 or 5)	**72**
N^{o} 'Poor' SJR scores (1 or 2)	**12**
N^{o} awaiting first or second review or arbitration	7
N^{o} Deaths judged more likely than not to be due to a problem in care	**0**

Table 2: Quarterly breakdown of neonatal reviews

	1st January 2019 to 31st March 2019 (Q4)
Total N^{o} neonatal deaths at STH [c]	2
N^{o} referred for SJR	2
N^{o} of SJR's carried out (or equivalent)	2

Table 3: Quarterly Reporting Requirements – January 2019 to March 2019

	1st January 2019 to 31st March 2019 (Q4)
Total deaths at Sheffield Teaching Hospitals NHSFT	791
Total deaths subject to a Medical Examiner review	538
Total deaths subject to Structured Judgement Review	89 (87 + 2) [c]
Deaths referred to the coroner	208
All deaths judged more likely than not to be due to a problem in care	0

Table 4: Category of Referrals

	1st January 2019 to 31st March 2019 (Q4)
Maternal	0
Neonatal	2
Learning Disability	10
Serious Mental Illness	3
Child (not neonatal)	0
Other Medical Examiner Referrals	78
TOTALS	**93 (89+2) [c]**

Key

[a] Medical Examiner Review – Undertaken in the immediate period following the death by the MES currently covering the Northern General Campus. The MES includes both Medical Examiners and Medical Examiner Officers.

[b] SJR – A validated and standardised retrospective case record review process.

[c] Additional cases from Neonatology Mortality Review, see below, p4 second paragraph.

Discussion

A total of 91cases from 538 deaths reviewed by the MES were referred for potential SJR which represents approximately 17 percent. The MES categorises the deaths in an identical fashion to those categories described in the Learning from Deaths guidance.

For 87 of the 91(96%) cases an initial SJR has been completed. 12 of these scored a one or a two (and included one case in the category of learning disability) and this represents 2.2% of deaths reviewed by the MES (12/538). Four of the 91 have not yet received an initial SJR, though each are scheduled for allocation to an Expert SJR Group reviewer in October 2019. These cases have been picked up through triangulation of mandatory learning disability deaths known to the Trust LeDeR Lead with mandatory cases referred from the Medical Examiner System.

Eight of the 12 cases have been referred to HM Coroner. For the remaining four, a Learning from Deaths directorate response has been requested or is in the process of being requested. Once all four directorate responses have been received they will be reviewed via the Mortality Governance Committee sign off process and any further appropriate referrals to the Serious Incident Group to scrutinise via a Paper A will be made.

[c] Neonatal Mortality Review - Both neonatal deaths were subject to a separate established mortality review process in the Jessop Wing. These two deaths were referred for SJR and both cases have been reviewed. We have defined a neonatal death as per MBRRACE reports (Live birth at 24 weeks of pregnancy or greater) and included deaths that occurred at STHFT or deaths that followed planned palliative care and death occurred at home or a hospice.

[d]Of the 91 cases referred for potential SJR by the MES or by triangulation with other sources, ten were deaths of patients with a learning disability and three were deaths of patients with severe mental illness. A SJR has been completed for nine of these cases. One of these nine cases scored a 2 and is in the process of being referred to the directorate for a Learning from Deaths directorate response.

In total 208, or 39% of cases were referred to Her Majesty's Coroner (HMC) by the MES. Please note the reasons for coroner investigation are many, often unrelated to possible problems in care.

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

Thematic Analysis
The key themes remain the same as those reported for Q3.

Analysis of the Datix SJR database has highlighted the following themes that are emerging from those cases that had an overall score of their care of poor(2) or very poor(1). These have been reported in the phases of care that are assessed using the SJR methodology.

Phase of Care	Themes	Actions / Work streams
First 24 hours of Care	• Poor Documentation • Issues around Clinical Review and Timeliness • Issues around Early Warning Scores	• Development of the EPR • Seven Day services work • NEWS2 has been implemented; electronic observations rollout; Deteriorating Patient Committee has been convened
Care during a procedure	• Good use of checklist	• Despite this issues remain with wrong site surgery and a Task and Finish group has been convened
Ongoing Care	• Issues around Clinical Review • Poor Documentation	• Seven Day Services • Development of the EPR
End of Life	• Poor Documentation • DNACPR process when related to poor patient care	• Development of the EPR • End of Life Care nurse lead is now established in post; Consideration of rolling out the ReSPECT process
	• Positive themes were: discussion, treatment, and documentation	• National Audit of Care at the End of Life (NACEL) currently being undertaken