SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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EXECUTIVE SUMMARY

REPORT TO THE TRUST BOARD

HELD ON 20TH DECEMBER 2017

Subject	Learning From Deaths
Supporting TEG Member	David Throssell
Author	Andrew Gibson on behalf of Mortality Governance Committee
Status[1]	A*

PURPOSE OF THE REPORT

This report is the quarterly report to the Trust Board on deaths in our care as required by the Learning from Deaths Guidance, March 2017 and amended in July 2017. This is the first such report which will be subject to continuous review of content.

From April 2017, Trusts have been required to collect and publish on a quarterly basis 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 (from Q3 onwards). This 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 these deaths subjected to review, Trusts will 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 Quarterly Learning from Deaths Report to the Trust Board considers all deaths at STHFT in scope.

The results for Sheffield Teaching Hospitals NHSFT 1st April – 30th June 2017 are as follows,

Total deaths at Sheffield Teaching Hospitals NHSFT	667(including 13 neonatal deaths)
Total deaths subject to a Medical Examiner review	533
Total deaths subject to Structured Judgement Review	12
Deaths referred to the coroner	216

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

Trust Board is asked to note the outcome.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	13/12/17	Y
Trust Board	20/12/17	

[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
Q1 (1st April – 30th June 2017)

This report is the quarterly report to the Trust Board on deaths in our care as required by the Learning from Deaths Guidance, March 2017 and amended in July 2017. This is the first such report which will be subject to continuous review of content.

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 [b].

Purpose of the report

The following is the Q1 Learning from Deaths Report to the Trust Board and considers all deaths at STHFT in scope. The report considers;

- All deaths subject to a Medical Examiner Review [a]
- All deaths subject to a Structured Judgement Review [b]
- All deaths judged more likely than not to be due to a problem in our care
- Key learning points from the overall review process

Key Findings

Table 1

Sheffield Teaching Hospitals NHS Foundation Trust	1 April – 30 June 2017
Total deaths at Sheffield Teaching Hospitals NHSFT	667
Total deaths subject to a Medical Examiner review	533
Total deaths subject to Structured Judgement Review	12
Deaths referred to the coroner	216
All deaths judged more likely than not to be due to a problem in care	0

Table 2

Category of Death	Number	SJR's undertaken	SJR Outcome <3
Maternal	0	0	0
Neonatal	13 [c]	0	0
Learning Disability	5 [d]	5	0
Serious Mental Illness	0	0	0
Child (not neonatal)	0	0	0
Other Medical Examiner Referrals	51	7 [e]	1 [f]
Total	**69**	**12**	**1 [f]**

[a] Medical Examiner Review – Undertaken in the immediate period following the death by the Medical Examiner's Office (MEO), currently covering the Northern General Campus.

[b] Structured Judgement Review – A validated and standardised retrospective case record review process.

[c] The 13 neonatal deaths were subject to a separate established mortality review process in the Jessop Wing which is in the process of being updated in line with Learning from Deaths Guidance and as described in our draft policy.

[d] 5 deaths of patients with a learning disability were reviewed by the MEO prior to the SJR being undertaken, giving a total of 56/533 (10.5%) cases referred by the MEO for potential SJR.

[e] Of the 56 cases referred for potential SJR by the MEO, twelve had the greatest concerns or were deaths of patients with a learning disability. This represents 2.3% of deaths reviewed (12/533). Mortality reviews

were undertaken using SJR methodology on these twelve cases and one of these scored less than three. This case is one of the serious untoward incidents below and also is to be the subject of a coronial inquest [f]. At present the Trust's agreed mortality review model is not fully implemented and the expectation is that all MEO referrals will be subject to a Structured Judgement Review in the future. The MEO will categorise the deaths in an identical fashion to those categories described in the LFD guidance.

[f] The death highlighted is currently the subject of an on-going SUI investigation and coronial inquest.

Serious Untoward Incidents

There were two deaths that have undergone a Serious Untoward Incident investigation. One of these has had an investigation undertaken, the actions of which are to be completed by 31st December 2017, and the other is currently awaiting coronial inquest [f].

Key Learning Points

The five deaths of patients with a learning disability have all undergone SJR. There were no serious concerns in the quality of care delivered and overall care scores were greater than three.

Those cases highlighted by the MEO as having concerns have also been subject to SJR and of the twelve reviewed there was one score less than three [f].

As a result of concerns in one of these cases the Trust has engaged with the newly formed Healthcare Safety Investigation Board (HSIB) who have undertaken an initial visit to the Trust. The Trust will continue to work with HSIB to determine if there is wider NHS learning to be obtained in respect of the generic issues surrounding the delivery of oxygen therapy.