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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECITIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS
HELD ON TUESDAY 30 JULY 2019

Subject	Learning From Deaths – Q4 2017/18 to Q2 2018/19
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Status[1]	A*

PURPOSE OF THE REPORT

This report is the quarterly report to the Board of Directors on deaths of patients under the care of STHFT as required by the Learning from Deaths Guidance, March 2017. This is the fourth such report and covers the period 1 January 2018 to 30 September 2018, taking into account three consecutive quarters of data.

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 2018 – 30th September 2018 are as follows,

- Total deaths at Sheffield Teaching Hospitals NHSFT 2192 (22 neonatal deaths)
- Total deaths subject to a Medical Examiner review 1940
- Total deaths subject to Structured Judgement Review 84 (plus 22 neonatal deaths)
- Deaths referred to the coroner 833 (359 accepted)

The Trust Expert Structured Judgement Review (SJR) Group has been in place since 17th September 2018 and since this point has started to review all referred cases.

IMPLICATIONS

AIM OF THE STHFT CORPORATE STRATEGY 2017-2020		**TICK AS APPROPRIATE**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centered 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 and be reassured by the findings and note that the Healthcare Governance Committee have debated and contributed with suggestions for further developments.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	10th June 2019	
Healthcare Governance Committee	15th July 2019	
Trust Board		

[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 2017/18 – Q2 2018/19 (1st January – 30th September 2018)

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.

This is the fourth such report covering the three quarters 1st January 2018 to 30th September 2018 and brings reporting closer to the Trust aim of reporting all closed work, except HM Coroner referrals which will be documented.

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 three quarters (Q4 2017-18 and Q1/Q2 2018-19) in order to bring reporting closer to 'real-time'.

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

	2017/18	**2018/19**		**Total**
	Q4	**Q1**	**Q2**	
Total N^{o} deaths STH	867	650	675	2192
N^{o} deaths NGH	**724**	**516**	**546**	**1786**
N^{o} deaths subject to a MES review[a]	**724**	**640**	**576**	**1940**
N^{o} deaths referred to HM Coroner	**357**	**238**	**238**	**833**
N^{o} deaths accepted by HM Coroner	130	115	114	359
N^{o} deaths referred by MES for SJR	**94**	**15**	**41**	**150**
N^{o} SJRs - first review[b]	**28**	**15**	**41**	**84**
(as a percentage of SJRs referred)	*30%*	*100%*	*100%*	
N^{o} 'Good' SJR scores(3, 4 or 5)	**27**	**12**	**32**	**71**
No. SJRs 'Poor' (Score 1 or 2)	**1**	**3**	**9**	**13**
No. Deaths judged more likely than not to be due to a problem in care	**0**	**0**	**0**	**0**

Table 2: Quarterly breakdown of neonatal reviews

	2017/18	2018/19		Total
	Q4	Q1	Q2	
Total N^{o} neonatal deaths at STH [c]	5	8	9	22
N^{o} referred for SJR	5	8	9	22
N^{o} of SJR's carried out (or equivalent)	5	8	9	22

Table 3: Totals over three quarters from January 2018-September 2018

Sheffield Teaching Hospitals NHS Foundation Trust	**1 Jan 2018 – 30 Sept 2018**
Total deaths at Sheffield Teaching Hospitals NHSFT	2192
Total deaths subject to a Medical Examiner review	1940
Total deaths subject to Structured Judgement Review	84 + 22 neonatal
Deaths referred to the coroner	833
All deaths judged more likely than not to be due to a problem in care	0

Table 4: Category of Referrals

	2017/18	2018/19		Total
	Q4	Q1	Q2	
Maternal	0	0	0	0
Neonatal	5	8	9	22
Learning Disability	12	4	5*	21[d]
Serious Mental Illness	4	5	4*	13[d]
Child (not neonatal)	0	0	0	0
Other Medical Examiner Referrals	12	6	32	50
TOTALS	**33**	**23**	**50**	**106**

* One patient had LD and SMI so is not counted twice

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.

Discussion

A total of 150 cases from 1940 deaths reviewed by the MES were referred for potential SJR which represents approximately eight percent.

The MES categorises the deaths in an identical fashion to those categories described in the Learning from Deaths guidance. Analysis shows that as the process has evolved at STHFT there is a clear trend for improved performance against the defined metrics.

For 84 of the 150 (56%) cases an initial SJR has been completed. 13 of these scored a one or a two (and included two cases in the category of learning disability and/or serious mental illness) and this represents

0.7% of deaths reviewed by the MES (13/1940). All of the 13 have been referred to the Serious Incident Group to scrutinise via a Paper A (five were already being investigated by the Serious Incident Group).

In Q1 and Q2 of 2018/19, 100% (56/56) of SJR's referred by the ME have had an initial SJR which has been an improvement from 2017/18 as the Expert SJR Group has matured.

[c] Neonatal Mortality Review - All 22 neonatal deaths were subject to a separate established mortality review process in the Jessop Wing. This is in the process of being updated in line with Learning from Deaths Guidance and as described in our policy. 22 deaths were referred for SJR and 22 cases were 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 150 cases referred for potential SJR by the MES, 21 were deaths of patients with a learning disability (two also had severe mental illness) and 13 were deaths of patients with severe mental illness. This represents 1.8% (34/1940) of deaths reviewed by the MES. A SJR has been completed for all 34 of these cases. Two of these cases scored a 2 and have been referred to the Serious Incident Group to scrutinise via a paper A (and are included in the total of 13 overall that scored 1 or 2).

In total 833, or 43% 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. 359 of the 833 referrals (43%) were accepted by HMC.

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 Organisational Development Department (ODD) and the Patient and Healthcare Governance Department are working together to agree and then test (by the end of 2019) a new process to link outcomes and themes arising from Serious Incidents, Never Events and Learning from Deaths to existing ODD workstreams, or to highlight the need for potential new transformational workstreams. The new National Patient Safety Strategy places emphasis on reviewing serious incidents from a 'system' rather than a local perspective, and this new process will support this approach.

The Datix database, in which we collect and analyse the outputs from the Structured Judgement Reviews, is cumulative. The implication of this is that any thematic analysis takes all uploaded cases into consideration, including the most recent. The benefit to the Trust is that the analysis of the themes is current, allowing for oversight of the immediate issues, therefore the most recent thematic analysis is included in the Q3 2018/19 paper, with associated actions, for oversight. The drawback is that trend analysis over time cannot be conducted, nor can analysis over particular time periods be undertaken.

During the reporting period 8 patients were ultimately referred to the Serious Incident Group for further action, the themes of which and the associated ongoing actions / work streams are summarised below;

Table 5: Identified themes

Case N[o]	Issues (Themes)	Actions	Comment
1	Escalation issues and Early warning scores	NEWS 2 roll out Deteriorating Patient Committee in place	Transition completed. Current work stream
2	Recognition of deterioration and Escalation issues	NEWS 2 roll out Deteriorating Patient Committee in place	Transition completed Current work stream
3	Paucity of consultant input	Seven-day Services Audit	Latest round completed June 2019
4	Sepsis	Deteriorating Patient Committee in place Sepsis Big Room	Both have current sepsis work streams

5	Inappropriate CPR in patient who had DNACPR and Lack of escalation	End of Life Care Group Lead Nurse	New appointment to take forward issues such as improving communication
6	Timeliness of consultant review	Seven-day Services Audit	Latest round completed June 2019
7	Delayed escalation and inadequate antibiotic therapy for Sepsis	Deteriorating Patient Committee in place Sepsis Big Room	Current work stream. Both have current sepsis work streams
8	Nasogastric Tube inserted into the lung	Robust local policy in place	