SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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

Subject	Learning From Deaths – Q3 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 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 fifth such report and covers the period 1st October 2018 to 31st December 2018, bringing the reporting in line with Trust requirements of six months from the end of the previous quarter.

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 October 2018 to 31st December 2018 are as follows,

- Total deaths at Sheffield Teaching Hospitals NHSFT 695 (5 neonatal deaths)
- Total deaths subject to a Medical Examiner review 554
- Total deaths subject to Structured Judgment Review 113 (plus 5 neonatal deaths)
- Deaths referred to the coroner 243 (111 accepted)

The Trust Expert Structured Judgment 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 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 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
Q3 2018/19 (1st October – 31st December 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 fifth such report covering the period 1st October – 31st December 2018 and brings reporting 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 October – 31st December 2018 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

	1st October 2018 to 31st December 2018 (Q3)
Total N^{o} deaths STH	695
N^{o} deaths NGH	**534**
N^{o} deaths subject to a MES review[a]	**554**
N^{o} deaths referred to HM Coroner	**243**
N^{o} deaths accepted by HM Coroner	111
N^{o} deaths referred by MES for SJR	**115**
N^{o} SJRs - first review[b]	**113**
(as a percentage of SJRs referred)	*98%*
N^{o} 'Good' SJR scores(3, 4 or 5)	**104**
N^{o} 'Poor' SJR scores (1 or 2)	**9**
N^{o} awaiting first review	2
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 October 2018 to 31st December 2018 (Q3)
Total N^{o} neonatal deaths at STH [c]	5
N^{o} referred for SJR	5
N^{o} of SJR's carried out (or equivalent)	5

Table 3: Quarterly Reporting Requirements - October 2018-December 2018

	1st October 2018 to 31st December 2018 (Q3)
Total deaths at Sheffield Teaching Hospitals NHSFT	695
Total deaths subject to a Medical Examiner review	554
Total deaths subject to Structured Judgement Review	113 + 5 neonatal
Deaths referred to the coroner	243
All deaths judged more likely than not to be due to a problem in care	0

Table 4: Category of Referrals

	1st October 2018 to 31st December 2018 (Q3)
Maternal	0
Neonatal	5
Learning Disability	4
Serious Mental Illness	6
Child (not neonatal)	0
Other Medical Examiner Referrals	105
TOTALS	**120 (115+5)**

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 115 cases from 554 deaths reviewed by the MES were referred for potential SJR which represents approximately 21 percent. The MES categorises the deaths in an identical fashion to those categories described in the Learning from Deaths guidance.

For 113 of the 115 (98%) cases an initial SJR has been completed. 9 of these scored a one or a two (and included one case in the category of learning disability) and this represents 1.6% of deaths reviewed by the MES (9/554). Two of the 115 have not yet received an initial SJR. In one case the notes are with the HM Coroner's Office and therefore not accessible for SJR. In the second case the SRJ has been allocated to an Expert SJR Group reviewer and the SJR is in progress.

One of the nine is being processed and for eight of the nine a Learning from Deaths directorate response has been requested. So far three of the eight responses have been received and one case is already

being investigated by the Serious Incident Group. Once all directorate responses have been received for this quarter they will be reviewed via the Mortality Governance Committee sign off process (pending confirmation from the Trust Executive Group for this recent process change) and any further appropriate referrals to the Serious Incident Group to scrutinise via a Paper A will be made.

[c] Neonatal Mortality Review - All five neonatal deaths were subject to a separate established mortality review process in the Jessop Wing. These five deaths were referred for SJR and all five 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 115 cases referred for potential SJR by the MES, four were deaths of patients with a learning disability and six were deaths of patients with severe mental illness. This represents 1.8% (10/554) of deaths reviewed by the MES. A SJR has been completed for all ten of these cases. One of these cases scored a 2 and has been referred to the directorate for a Learning from Deaths directorate response. This case will be referred to the SI Group.

In total 243, or 44% 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. 111 of the 243 referrals (46%) 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.

Analysis of the Datix SJR database on the 25th June 2018 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 the 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
	• With regards families the key 'good' themes were discussion, treatment and documentation	• National Audit of Care at the End of Life (NACEL) currently being undertaken