EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS HELD ON 27 JULY 2021

Subject	Learning from Deaths Report – Q3 (1st October – 31st December 2020)
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Status[1]	A*

PURPOSE OF THE REPORT

This 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 Q3 of 2020/21 (1st October – 31st December 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 October – 31st December 2020 as follows:

- Total no. deaths at STHFT — 857 (+ 5 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR) — 27 (22 + 5 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[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

The Board of Directors is requested to note the content of the report in the context of the COVID-19 pandemic, and the resultant backlog of SJRs.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	7 July 2021	Y
Healthcare Governance Committee	19 July 2021	Y
Trust Board of Directors	27 July 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

Learning from Deaths Report

Q3 2020/21 (1st October – 31st December 2020)

1. Introduction

This report is the quarterly report to the Trust Executive Group 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 acute hospital care 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

Appointment to a third MEO post in November 2020 coincided with the departure of the Lead MEO and hence the 1.8 whole time equivalent staffing was still a shortfall from the recommended 2.9 whole time equivalents advised by NHS England and NHS Improvement for a Trust with approximately 2,900 deaths. Recruitment to the Lead MEO post has been unsuccessful and has been put on hold. Recruitment of an additional 1.0 whole-time equivalent MEO is in the active recruitment phase (commences July 2021).

This report covers a period of optimal ME staffing but includes the start of the second wave of the COVID-19 pandemic which placed additional demands on MEs and MEOs. This may be replicated in future quarters due to the COVID-19 pandemic.

Table 1 presents the number of adult deaths and reviews at STHFT during the period 1st October – 31st December 2020. During this quarter, there has been an increase in the number of deaths (857) compared with those reported a year ago in the Q3 Report 2019/20 (753) and 732/857 (85.4%) have received an ME review. This is a decrease from the Q2 2020/21 reported figure of 97%.

3. Learning from Deaths Cases Reviewed

Five neonatal deaths have been 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. Information on neonatal review in Q3 2020/21 is included in a separate report quarterly to the Trust Executive Group.

22 of 857 (2.6%) adult and five of five (100%) neonatal deaths occurring in Q3 have been subject to SJR (Table 1). An additional 32 (3.7%) adult cases are awaiting a first review. The pressures of COVID-19 impacting the capacity of the SJR Expert Group, the loss of experienced Expert Review Group staff to ME posts in Q1 and the availability of case records have been limiting factors for the number of SJRs carried out. As a result fewer SJRs were undertaken.

Six new reviewers were appointed in December 2020 and will start to address the backlog of cases during Q4 (January to March 2021).

Table 1: Quarterly breakdown of adult reviews

	1st Oct – 31st Dec 2020 (Q3)
Total number of adult deaths at STHFT	857
No. of adult deaths subject to an ME review	732
No. SJRs completed	22
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

Table 2 shows the number of cases within the mandatory categories of referrals for SJR (54). 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 where ME referral alone is the determinant. Processes were also agreed with the Trust Learning Disabilities Mortality Review (LeDeR) Lead to ensure that all patients with a learning disability were correctly identified.

Table 2: Mandatory categories of SJR referrals

	1st Oct – 31st Dec 2020 (Q3)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	7
Learning disabilities or with severe mental illness	19
Learning will inform the provider's existing or planned improvement work	12
Not expected to die (e.g. in relevant elective procedures)	14
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. Covid-19	2
Total referrals	**54**

In this quarter, 100 adult cases were notified to the coroner after scrutiny by an ME and taken for investigation. It should be noted that there are many statutory reasons to refer a case for coronial inquiry which are often not related to concerns about care.

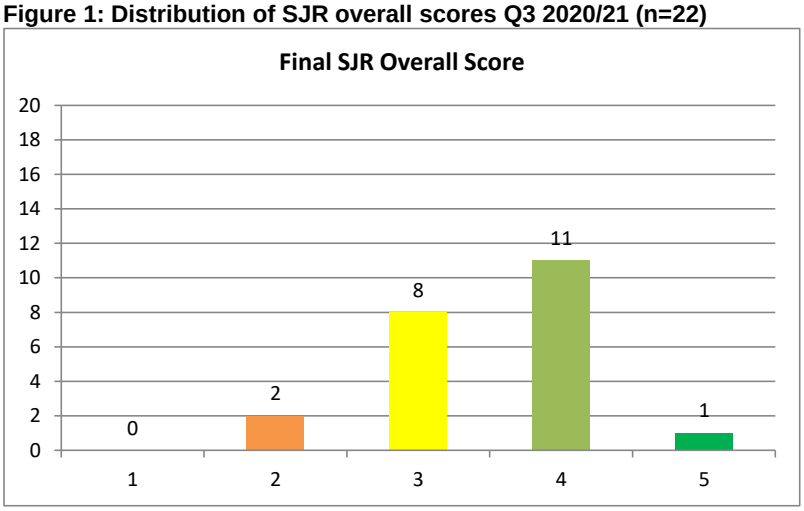
Of the 22 completed adult SJR cases, three were deaths of patients with a learning disability and five were deaths of patients with a serious mental illness. Seven cases scored three or greater (good care) and one scored 2 (poor). This case has been escalated to the Mortality Governance Committee and is awaiting a Coroner's Inquest in July 2021. 11 cases relating to patients with learning disabilities or severe mental illness are still awaiting a first review.

Of the deaths subject to SJR during this period (22), 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 22 adult SJRs completed, two (9%) had a score of less than three. These cases received a second review, with the score remaining less than three. Both cases have been referred back to the directorate for responses including any relevant clinical context and escalated to the Mortality Governance Committee. Figure 1 shows the distribution of SJR overall scores for the 22 completed SJRs.

Figure 1: Distribution of SJR overall scores Q3 2020/21 (n=22)



5. Serious Incident Actions

One death was reported as a Serious Incident in December 2020 following a SJR score of 2 (death was in June 2019). This related to a patient admitted to Weston Park Hospital for an ascitic drain insertion who deteriorated over the subsequent days. A number of issues were identified by the SJR, including a missed opportunity to identify, escalate and treat infection, fluid balance monitoring, communication with the family and the bereavement process.

6. Regulation 28 Notifications and Prevention of Future Deaths

There were no Regulation 28 Notifications from the outcomes of Coroner Inquests in this quarter

7. Learning from Mortality Analysis

a) Actions arising from SJR scores less than three

The Mortality Governance Committee has raised issues relating to DNACPR in this quarter which will be discussed at the Deteriorating Patient Committee by the Medical Director (Operations) and the Trust End of Life Care Lead.

b) Themes identified by SJR and Mortality Governance Committee

Mortality Governance Committee responsibility 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.

A recent recurring theme is documentation in healthcare notes (ensuring that names, designation, date and times of signatures is clear) and the legibility of handwriting. A new emerging theme is nursing documentation, particularly in relation to fluid balance charts and nutrition and completion of end of life care plans. Risks have been identified and incorporated into the Trustwide healthcare records risk assessment led by the Healthcare Records Committee.

c) Learning from Deaths Update newsletter

The first Learning from Deaths Update newsletter was circulated in December 2020 in response to feedback from directorates about improving communication about the SJR process and reporting from Mortality Governance Committee.

As the MGC meetings scheduled for November and December 2020 2020 were cancelled due to clinical COVID-19 and non quoracy. Any pertinent feedback will be included in the Q4 Learning from Deaths report.