Sheffield Teaching Hospitals NHS
NHS Foundation Trust

EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS

HELD ON 27 OCTOBER 2020

Subject	Learning From Deaths Report – Q4 (1st January – 31st March 2020)
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Status[1]	A*

PURPOSE OF THE REPORT

This report 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 Q4 of 2019-20 (1st January – 31st March 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 January – 31st March 2020 as follows:

- Total no. deaths at STHFT 768
- Total no. deaths subject to Structured Judgment Review (SJR) 27
- 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 Trust Board of Directors is requested to note the contents of the report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	07 -10 - 2020	Y
Healthcare Governance Committee	19 -10 - 2020	Y
Trust Board of Directors	27 -10 - 2020	

[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

*Data source: Bereavement Database & Neonatology Mortality Lead

Learning from Deaths Report

Q4 2019/20 (1st January – 31st March 2020)

1. Introduction

This report is the quarterly report to the Healthcare Governance Committee 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 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

The Trust has had a total of 10.5PAs of ME time (1.1 whole time equivalents) in place since 1st July 2020 and as of 1st June 2020, 100% of deaths occurring at the NGH and a proportion of deaths at the RHH have a ME review and the mandatory cases, along with a selection of further cases, have an SJR.

Appointment to a third MEO post has brought the Trust to 2.6 whole time equivalents from November 2020, and closer to the recommended 2.9 whole time equivalents advised by NHS England and NHS Improvement for a Trust with approximately 2900 deaths.

This report covers the period prior to the increase in ME and MEO staffing and includes the period in March when COVID-19 started to impact the number of deaths and the availability of reviewers. In addition the publication of national guidance advised standing down MES's during the pandemic. As a result of these issues fewer ME reviews were performed and fewer structured judgement reviews were undertaken. It is possible that this position may be replicated in the next two quarters.

3. Learning from Deaths cases reviewed

Table 1 provides the quarterly breakdown of neonatal reviews in Q4, 2019-20. All seven neonatal deaths were 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. The term 'neonatal death' now includes live births greater than 22 weeks gestation, as there is new national guidance about resuscitation at this gestation, and includes deaths that occurred at STHFT or deaths that followed planned palliative care where death occurred at home or in a hospice. There has been a delay in carrying out SJRs due to the impact of COVID-19, however the two outstanding SJR's from Q3 were completed in Q4.

Table 1: Quarterly breakdown of neonatal reviews

	1st Jan – 31 Mar 2020 (Q4)
Total no. neonatal deaths at STHFT	7
No. referred for SJR equivalent	7
No. SJR equivalent carried out	7

Table 2 presents the number of adult deaths and reviews at STHFT during the period 1st January 2020 – 31st March 2020.

Table 2: Quarterly breakdown of adult reviews

	1st Jan – 31 Mar 2020 (Q4)
Total no. deaths STHFT	761
No. deaths subject to a ME review	216
No. SJRs completed	20
No. SJRs score <3 (poor care)	1
Of the deaths subject to SJR, no. deaths judged more likely than not to be due to a problem in care	0

From Tables 1 and 2 it can be seen that during the Q4, a total of 20 adult and seven neonatal deaths were subject to SJR (4%). Two further adult cases have received a first review and are awaiting a second review and 32 adult cases are awaiting first review.

Table 3 shows the number of cases within the mandatory categories of referrals for SJR. Cases in the category 'not expected to die' were identified retrospectively from 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 we have seen in previous quarters where ME referral was the determinant. Processes were also agreed with the Trust LeDeR Lead to ensure that all learning disabilities patients were identified. Due to the pressures of Covid-19, the capacity of the SJR Expert Group at the end of Q4 and availability of case records have been limiting factors for the number of SJRs carried out.

11 of the 26 cases from the 'not expected to die' category shown in Table 3 are awaiting allocation, eight have been allocated and are awaiting first review, two are awaiting second review and five have been completed with scores of either three or four. 248 cases were referred to HM Coroner (HMC) by the MES. It should be noted that the reasons for Coroner investigation are many, and are often not related to concerns about care.

Table 1: Mandatory categories of SJR referrals

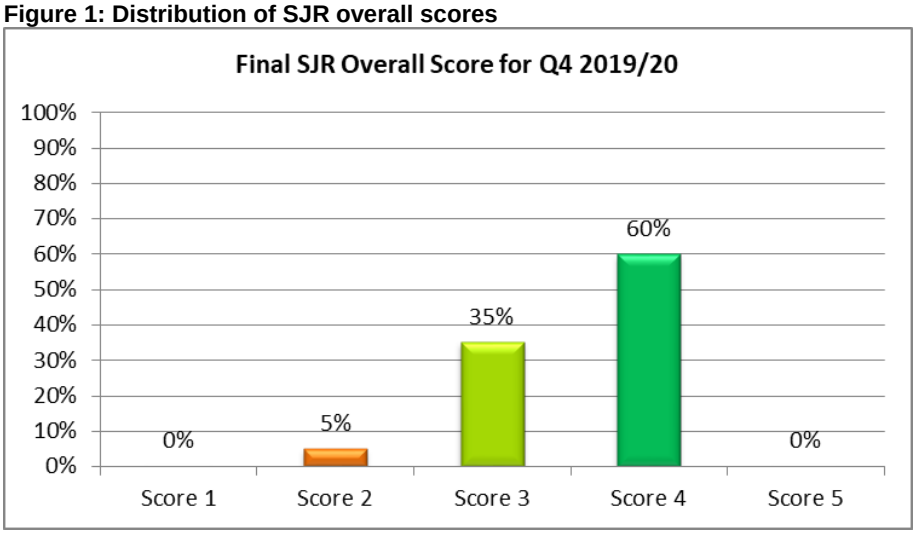
	1st Jan – 31 Mar 2020 (Q4)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	3
Learning disabilities or with severe mental illness	6
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. Covid-19	3
Not expected to die (e.g. some elective procedures)	26
Learning will inform the provider's existing or planned improvement work	8
Reason for referral not stated	8
Total referrals	**54**

Of the 20 completed SJR cases, four were deaths of patients with a learning disability and one was the death of a patient with serious mental illness. A SJR has been completed for five of these cases with all five scoring three or greater (good care). One learning disabilities case is still awaiting a first review. Of the deaths subject to SJR during this period, 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 20 adult SJRs completed, one (5%) had a score of less than three. This case received a second review, with the score remaining less than three. Figure 1 shows the distribution of SJR overall scores for the 20 completed SJRs. 60% scored four or five.

Figure 1: Distribution of SJR overall scores



5. Learning from mortality analysis

The Learning from Deaths Facilitator co-ordinates all aspects of the process including ensuring SJR cases are allocated to reviewers appropriately, case notes are made available to reviewers in a timely way, and reviews are completed and entered via the Datix platform. The Facilitator also acts as the SJR database manager, dealing with routine and ad hoc queries and assists with analysis of the data collected to identify learning.

a) Actions arising from 'poor' SJRs

For the one case following second review that was rated as 'poor care' overall, directorate context and an action plan have been requested prior to review at the Mortality Governance Committee. There is a related incident for this case and an on-going inquest. The Legal Services Department has been informed of the SJR outcome.

Three cases have recently been discussed at the Mortality Governance Committee:

- One case with actions specifically relating to DNACPR and family discussion has been referred to the Resuscitation Committee for further action and shared learning.
- One case with actions specifically relating to oxygen prescribing and administration has been referred to the Medical Gases Committee for further action and shared learning. This has been fed into a wider piece of improvement work relating to oxygen management.
- One case was referred to the Serious Incident Group for a Paper A and was subsequently reported as an Internal Serious Incident. This case is awaiting an Inquest.

b) Serious Incident Actions

One death in this reporting quarter was reported as an Internal Serious Incident. An investigation has been completed and has identified learning points and actions to be taken around management of the deteriorating patient, particularly involving nursing documentation and the monitoring of fluid balance which will be re-audited in October 2020.

c) Learning and Feedback on the SJR Process

The SJR Expert Group and Mortality Governance Committee have been reviewing all feedback received from reviewers, directorate governance leads and senior clinicians within the Trust. In response to this feedback, a 'Learning from Deaths Improvement Plan' is being developed, led by the Deputy Medical Director. Improvements include:

- 10% of all completed SJRs (including those scoring three or above) will be quality checked by the Deputy Medical Director on a monthly basis.
- Second reviewers will be blinded to the outcome of the first review
- A proportion of SJRs scoring three or above will receive a second review to eliminate bias for second reviews.
- All SJRs will be cross-referenced to Datix to identify any linked incidents, complaints, claims or inquests. Datix is being amended to enable triangulation.
- An advanced training session will be scheduled for the SJR Expert Group, to include further training on the various patient information systems.
- A four-monthly newsletter will be produced and circulated to Governance Leads to improve communication and shared learning.
- Recruitment of medical SJR Expert reviewers to fill the current vacancies will take place in October 2020.

d) Themes identified by SJR and Mortality Governance Committee

Mortality Governance Committee responsibility now 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 and include:

- Record Keeping – the quality of clinical records could be improved, particularly in terms of being fragmented, with illegible entries, gaps in documentation and timings of entries.
- Cognitive Screening – limited evidence to show this is consistently undertaken on admission
- Identification of Consultant on ward round, particularly where a junior doctor documents the plan in the notes.