EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS

HELD ON 28 JULY 2020

Subject:	Learning From Deaths Report – Q3 (1st October – 31st December 2019)
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Status[1]	A*

PURPOSE OF THE REPORT:

This report is the quarterly report to the 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 2019-20 (1st October – 31st December 2019).

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 2019 as follows:

Total N^{o} deaths at STHFT	761**
Total N^{o} deaths subject to Structured Judgment Review (SJR)	47
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:

	Aim of the STH Corporate Strategy 2017-2020	Tick as Appropriate
1	Deliver the best clinical outcomes	✓
2	Provide Patient Centred Care	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATION(S):

The Board of Directors is requested to note and discuss the findings and to contribute to the ongoing development of this report and the learning it aims to promote.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	8th July 2020	Y
Healthcare Governance Committee	20th July 2020	Y
Trust Board of Directors	28th July 2020	

**Data source: Bereavement Database & Neonatology Mortality Lead

Learning from Deaths Report

Q3 2019/20 (1st October 2019 – 31st December 2019)

a) Introduction

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). 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.

b) STHFT Medical Examiner System

The Trust has benefitted from a well-established Medical Examiner System (MES) based at the Northern General Hospital (NGH) site, established as part of a national pilot project that ended in March 2019. The pilot phase of this work lasted almost a decade and during this time STHFT was able to establish a system which scrutinised approximately 85% of deaths at STHFT.

From April 2019 the Medical Examiner (ME) led system began roll out within hospitals in England and Wales as a non-statutory system whereby all deaths will be subject to either ME scrutiny or a Coroner's investigation following full implementation. At STHFT, the lead ME was subsequently recruited to a national role and ceased to deliver the ME function at the Trust in May 2019. Additional to this, the Trust Lead Medical Examiner Officer (MEO) was appointed to a national role and left the Trust in November 2019. These two major changes significantly reduced the Trust's MES capacity. Subsequent appointments to these two vacancies culminated in the new Lead ME starting 1st January 2020 and the new Lead MEO starting 18th February 2020.

The Trust has recruited to the additional ME roles required to review all deaths so that, where feasible, work can begin on the training aspects of their roles. This will take effect from 1st July 2020 when the Trust will have in place a total of 10.5PA's of ME time (1.1 whole time equivalents). At the end of the non-statutory phase, or prior to this if possible, the plan is that 100% of deaths occurring across the Trust have a ME review and the mandatory cases, along with a selection of further cases, have a SJR.

An additional MEO has also been recruited and took up post in support of the Lead MEO on 26th May 2020. Recruitment to a third MEO post is being actively pursued to bring the Trust closer to the recommended three whole time equivalent MEO's for every 3000 deaths advised by NHS England and NHS Improvement.

The implementation of the national ME system in this non-statutory phase has been suspended during the COVID-19 pandemic. The number of cases subject to scrutiny within both the MES and LfD process during this time will be reduced as the clinicians who conduct the ME work and the SJR work are utilised in delivering their primary clinical functions. In addition, three of the ME's recruited have stepped down as members of the Expert SJR Group and need to be replaced, further impacting on SJR capacity. Once

past the peak of COVID-19 cases, all acute trusts in England should resume their work on Medical Examiner implementation as soon as possible as this is a priority for NHS England and NHS Improvement

c) Learning from Deaths cases reviewed

Table 1 provides the quarterly breakdown of neonatal reviews in Q3. Of eight neonatal deaths, six 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, but the process us now up and running again and it is envisaged that any outstanding SJR's will be completed by the end of July.

Table 1: Quarterly breakdown of neonatal reviews

	1st Oct – 31st Dec 2019 (Q3)
Total N^{o} neonatal deaths at STHFT	8
N^{o} referred for SJR	8
N^{o} SJRs (or equivalent) carried out	6

Table 2 presents the number of adult deaths and reviews at STHFT during the period 1st October 2019 – 31st December 2019.

Table 2: Quarterly breakdown of adult reviews

	1st October – 31st December 2019 (Q3)
Total N^{o} deaths STHFT	753
N^{o}. deaths subject to a ME review	77
N^{o} SJRs completed	41
N^{o} SJRs score <3 (poor care)	4
Of the deaths subject to SJR, the N^{o} 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 period 1st October – 31st December 2019, a total of 41 adult and six neonatal deaths were subject to SJR (6%). Two further adult cases have received a first review and are awaiting a second review. 21 adult cases and two neonatal cases are awaiting a first review. 19 of the 21 adult cases are from the category 'not expected to die' and these were identified retrospectively from hospital elective deaths data during Q4 (January to March 2020). As the Lead MEO had left the Trust in November 2019 and the ME resource was also depleted, this was one of the steps taken to ensure appropriate cases for SJR would not be missed. However, it resulted in many more cases being included from this category than in previous quarters as not all deaths following elective admissions fall into the category 'not expected to die'. Processes were also agreed with the Trust LeDeR Lead to ensure all learning disabilities patients were identified (see Table 3). 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 SJR's carried out. 18/30 cases from the 'not expected to die' category are awaiting allocation, one has been allocated and is awaiting first review, one is awaiting second review and 10 have been completed with scores of either three or four.

277 cases were referred to HM Coroner (HMC) by the MES. It should be noted that the reasons for Coroner investigation are many, often unrelated to possible problems in care.

Table 3 shows the number of cases within the mandatory categories of referrals for SJR.

Table 1: Mandatory categories of SJR referrals

	1st October– 31st December 2019 (Q3)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	1
Learning disabilities or with severe mental illness	7
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised	0
Not expected to die (e.g. some elective procedures)	30
Learning will inform the provider's existing or planned improvement work	17
Reason for referral not stated	9
Total referrals	**64**

Table 3 shows that of the 41 completed SJR cases, four were deaths of patients with a learning disability and three were deaths of patients with serious mental illness. A SJR has been completed for all seven of these cases with four scoring three or greater (good care) and three score less than three (poor care).

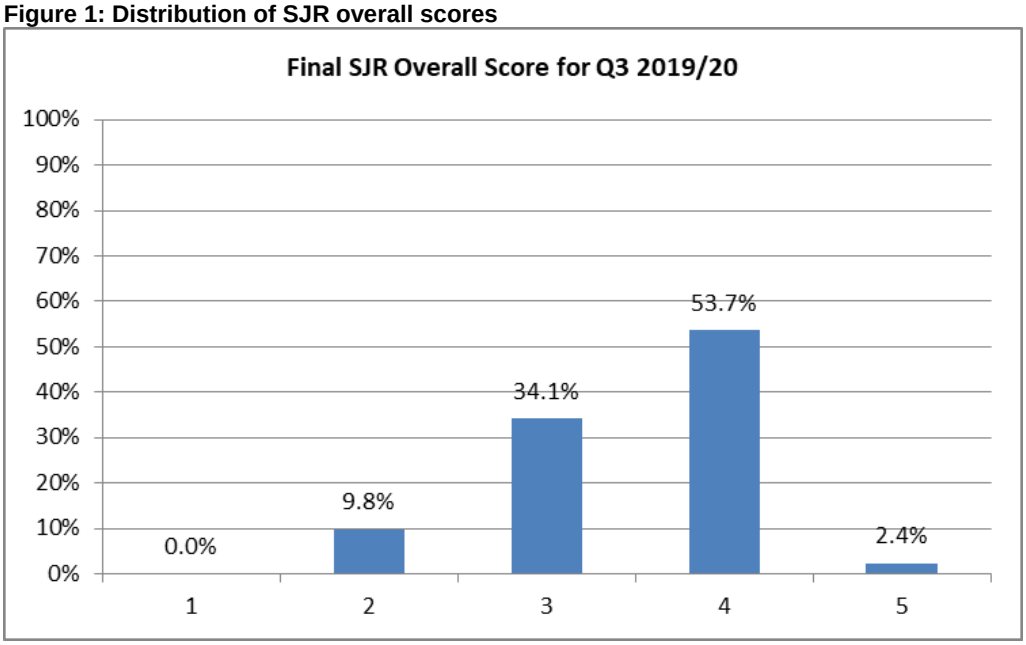
The actions arising from these three 'poor' cases (two mental health and one learning disability), is provided in section 5a.

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.

d) Distribution of scores

Of the 41 adult SJR's completed, four (10%) had a score of less than three. All four had a second review and two of these were referred for arbitration, with the score remaining less than three. Figure 1 shows the distribution of SJR overall scores for the 41 completed SJR's – 23 (56%) scored four or five.

Figure 1: Distribution of SJR overall scores



e) 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

Of the four cases following second review that were rated as 'poor care' overall;

- Directorate context and an action plan have been provided for one case prior to review at the Mortality Governance Committee (severe mental illness case)
- One directorate response is awaited and will be scheduled for MGC review once received (reason for referral for SJR not stated)
- The directorate is to be informed of the SJR outcome and a response requested following recent completion of the second review (learning disabilities case)
- One case was identified as a Serious Incident (SI) by the relevant directorate and was referred to the Serious Incident Group. This case was declared a CCG reportable SI (severe mental illness case)

b) Serious Incident Actions

As already mentioned, one death in this reporting quarter had associated serious incidents reported to the CCG. An investigation has been completed and identified some key learning points and actions to be taken in the Emergency Department and Ambulance Service. .

c) Learning from Deaths in Integrated Geriatric & Stroke Medicine (IGSM)

All SJRs regardless of outcome are recorded on the local SJR database. A quarterly summary is produced and reviewed at the IGSM Quarterly Governance meeting. Specific SJRs are selected for in-depth reviews, either because the outcome has been graded as poor (<3), or less frequently because the death is also subject to a coronial review.

Once the Governance team is notified of a poor outcome, details are recorded on the local SJR database and reviewed at the weekly Governance and Datix meeting attended by the medical governance lead, governance co-ordinators and risk management lead for the directorate. The medical governance lead then undertakes in-depth review of the case notes. Typically this review takes between three and four hours. This review is the basis for a one-hour presentation and discussion at the multidisciplinary mortality meeting with attendance from the governance team, senior nursing staff and all grades of medical staff, including all NGH site consultants. Staff from other directorates and disciplines are invited to attend if they have been directly involved in care. RHH IGSM consultants have previously been sent summary slides due to split-site working. In the post COVID environment these meetings will now be conducted via Microsoft Teams which will cover both sites.

Meeting attendees are asked to rate care against the same aspects of care as the SJR with a show of hands and the majority decision is recorded. A system for this has not yet been established using Microsoft Teams but an electronic solution will be sought. Notes and the summary are sent to all senior IGSM staff post-meeting for further feedback. Following this meeting the Learning from Deaths (LfD) Response Form is completed by the governance team and medical governance lead with as much detail as possible. This summarises the mortality review completed by the medical governance lead and the learning and comments from the multidisciplinary meeting providing a contextualised review. Any action points/learning are identified and updated on the local SJR database and progress monitored. These are reviewed at the weekly Governance meetings to ensure any outstanding actions on the LfD Response Form are completed (within IGSM control).

Typically the feedback is very detailed. Over the past 12 months important directorate and Trustwide learning has been identified.

Due to the number of SJRs within the directorate, in-depth reviews of those SJRs with a positive or adequate outcome are not currently performed. Details are recorded on the local SJR database and feedback on all SJRs can be given to base ward teams quarterly to inform local learning.

Specific examples of impact of SJR on the IGSM directorate from past 12 months include:

1. Documentation of escalation decisions and DNACPR. Re-design of the Post Take Ward Round sheets with cycles of audit competed to improve documentation of resuscitation status for all admissions to the Frailty Unit. The third audit is now complete and data analysis is underway. Significant improvements recorded in documentation and senior levels of decision making. Very positive impact.
2. Piloting work on the benefits of additional consultant presence at weekends for routine ward work – still under evaluation.
3. Inaccuracies with fluid balance – Identified this as an issue following SJR review but noted that by time the case was reviewed, revised fluid balance charts were already in place within the Trust. Whilst SJR did not have any effect on the re-design, it did highlight the previous problems with the old charts.

f) Analysis of MI cases identified via Dr Foster

Dr Foster reporting had identified an increased number of deaths associated with Myocardial Infarction (MI) admissions. SJR's were carried out on a proportion of these cases and of the 37 completed, 34 scored three or higher (good care), two scored less than three (poor care) and one is awaiting arbitration. Directorate context and action plans have been received for the two cases which scored less than three and these are scheduled to be discussed at the MGC in July 2020. Key actions included education relating to oxygen safety for one case and improved documentation, particularly with regards family discussions, for the second. The second case was also a Coroner's Inquest, although no outcome has been received to date.

g) Prevention of Future Death (Regulation 28) reports relating to SI's closed between 1 October 2019 and 31st December 2019

An inquest was held on 4 February 2020, following which a Regulation 28 report was received on 11 February 2020. This case relates to a SI that was closed in December 2019 and reported to TEG and HCGC in January 2020:

The Regulation 28 report identifies key Matters of Concern and further actions required in relation to:

- Strengthening the Standard Operating Procedure for Ward Meal Services
- Trust-wide provision and completion of staff training for International Dysphagia Diet Standardisation descriptors
- Improving processes to ensure that information regarding patients' specialist nutritional requirements is available and acted upon appropriately

A response to HM Coroner was provided by the deadline of 4 April 2020 to each of these issues and is summarised below:

Training for staff in relation to International Dysphagia Diet Standardisation Initiative (IDDSI) descriptors

The IDDSI was implemented within the Trust in October 2018, when a cascade training model was adopted. The following additional actions have now been agreed:

- IDDSI training will be added to Job Specific Essential Training (JSET), making it necessary training for all hospital and intermediate care based registered nurses, clinical support workers, trainee nursing associates, and housekeepers involved in mealtime procedures.
- IDDSI training will be delivered through an e-learning package entitled 'Meal Service Safety'. This will consist of three elements: IDDSI, the Trust's SOP for Ward Meal Services and the handling of hot food.
- IDDSI training for bank and agency staff who are not STH staff is to be discussed with NHS Professionals.