EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS

HELD ON 27 APRIL 2021

Subject:	Learning from Deaths Report – Q2 (1st July – 30th September 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 Q2 of 2020/21 (1st July – 30th September 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 July – 30th September 2020 as follows:

- Total no. deaths at STHFT — 466 (458 + 8 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR) — 30 (22 + 8 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:

	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 the content of the report in the context of the COVID-19 pandemic.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	24th March 2021	Y
Healthcare Governance Committee	19th April 2021	Y
Trust Board of Directors	27th April 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

Q2 2020/21 (1st July – 30th September 2020)

1. **Introduction**

This report is the quarterly report to the Trust 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.

2. **STHFT Medical Examiner System**

The Trust has a total of 10.5PAs of Medical Examiner (ME) time (1.05 full- time equivalents) in place since 1st July 2020. Since 1st June 2020, almost 100 per cent of deaths received a ME review (Table 1) and the mandatory cases, along with a selection of further cases, were referred for an SJR. The total Medical Examiner Officer (MEO) full-time equivalent at the end of the quarter is 1.8, which is below the national model of 3.0 full-time equivalents per 3,000 deaths scrutinised. Recruitment of an additional MEO is underway.

This report covers the period immediately following the increase in ME staffing and includes the first wave of the COVID-19 pandemic which impacted upon the availability of ME's (national guidance advised standing down ME's during the pandemic if they were needed more urgently elsewhere). The pandemic also reduced the availability of the Expert Review Group and as a result fewer SJRs were undertaken. This may be replicated in future quarters due to the COVID-19 pandemic.

3. **Learning from Deaths Cases Reviewed**

Eight 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 Q2 2020/21 is included in a separate report quarterly to the Healthcare Governance Committee.

Table 1 presents the number of adult deaths and reviews at STHFT during the period 1st July – 30th September 2020. During this quarter, there has been a reduction in the number of deaths (466) compared with those reported a year ago in the Q2 Report 2019/20 (617) and 453/466 (97%) have received an ME review. This is an improvement over the Q1 2020/21 reported figure of 61%.

During Q2, a total of 22 adult and eight neonatal deaths were subject to SJR (6.4%). An additional 35 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. However, six new reviewers were appointed at the end of 2020 and will start to address the backlog of cases.

Table 1: Quarterly breakdown of adult reviews

	1st July – 30th Sept 2020 (Q2)
Total number of adult deaths at STHFT	458
No. of adult deaths subject to an ME review	445
No. SJRs completed	22
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

Table 2 shows the number of cases within the mandatory categories of referrals for SJR. 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 we have seen in previous quarters where ME referral alone was 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 July – 30th Sept 2020 (Q2)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	9
Learning disabilities or with severe mental illness	17
Learning will inform the provider's existing or planned improvement work	15
Not expected to die (e.g. in relevant elective procedures)	11
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. Covid-19	5
Total referrals	**57**

In this quarter 85 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.

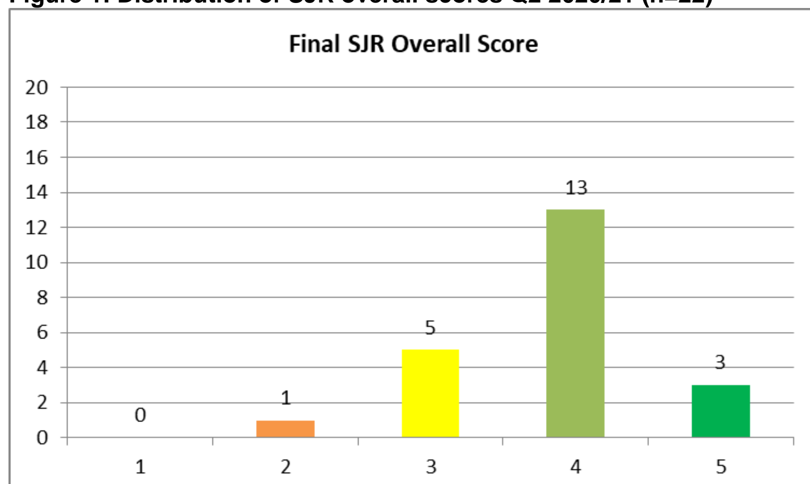
Of the 22 completed adult SJR cases, eight were deaths of patients with a learning disability and one was the death of a patient with a serious mental illness. All nine cases scored three or greater (good care). Eight cases relating to patients with learning disabilities or severe mental illness are 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, one (4.5%) 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 22 completed SJRs.

Figure 1: Distribution of SJR overall scores Q2 2020/21 (n=22)



5. Serious Incident Actions

Two deaths were reported as Serious Incidents in this reporting quarter as a result of structured judgement review.

6. Regulation 28 Notifications

No deaths in this reporting quarter received a Regulation 28 Notification from the Coroner.

7. Learning from Mortality Analysis

a) Actions arising from SJR scores less than three

Following Mortality Governance Committee intervention the Directorate has reflected on the outcome of the SJR process and referred the case to the Serious Incident Group. The result of a coronial inquest is awaited.

b) New Trust Reporting System for Mortality

Further to receiving formal notification that the national electronic Datix platform for mortality review would cease on 2nd January 2021, the PALS module within Datix has been re-purposed and re-designed to suit the needs of the SJR process and Trust requirements. This allows SJRs to be linked to existing related incidents, claims, complaints and inquests. The new module went live on 2nd January 2021, and all data from the previous system was extracted, reassigned to the new fields and transferred across to the new module in March 2021.

c) 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. A recent recurring theme is documentation in healthcare notes (ensuring that names, designation, date and times of signatures is clear). A full review of healthcare records is being undertaken across the Trust and comments from the Mortality Governance Committee and SJR Expert Group have been fed into this process. Risks have been

identified and incorporated into the Trustwide healthcare records risk assessment led by the Healthcare Records Committee

d) Review of Pre- and Post-COVID Learning Disability Deaths

A review of 120 SJR cases in three categories is being undertaken to review care of those patients with and without a known learning disability who died prior to the COVID-19 pandemic, who died during the pandemic but not of COVID-19 and those patients who died of COVID-19. This is being undertaken with Sheffield CCG and Sheffield Health and Social Care Trust as part of a wider review of deaths in patients with a learning disability.

e) Review of COVID19 Deaths

A review of 37 randomly selected patients where COVID-19 appears on the death certificate is being undertaken as part of a wider Royal College of Physicians (RCP) national review of COVID-19 deaths and is scheduled for reporting to the MGC in April 2021.