EXECUTIVE SUMMARY

REPORT TO THE TRUST BOARD OF DIRECTORS

HELD ON 30 NOVEMBER 2021

Subject:	Learning from Deaths Report – Q4 (1st January – 31st March 2021)
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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 dated March 2017. This report covers Q4 of 2020/21 (1st January – 31st March 2021).

KEY POINTS:

The Learning from Deaths Report considers deaths at STHFT in the period 1st January – 31st March 2021 as follows:

- Total no. deaths at STHFT — 918 (+ 9 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR) — 35 (26 + 9 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

There is one death that relates to the period January – March (Q4) 2019/20 which has been identified as more likely than not due to a problem in care. This case is explained in section 6 of the report which also includes the learning identified from the death.

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 Trust 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	6th October 2021	Y
Healthcare Governance Committee	18th October 2021	Y
Trust Board of Directors	30th November 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

Q4 2020/21 (1st January – 31st March 2021)

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 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

During Q4 of 2020-21 Medical Examiner (ME) staffing was 1.05 whole time equivalents (WTE). The national model is 1.0 WTE per 3000 deaths (which includes 0.08 WTE to administer the SJR process). The recommended Medical Examiner Officer (MEO) staffing is 2.9 WTE for a Trust with approximately 2,900 deaths and an additional WTE MEO commenced in July 2021 taking us to 2.8 WTE. This report covers a period which includes the second wave of the COVID-19 pandemic (September 2020 to April 2021) which placed additional demands on MEs and MEOs.

Table 1 presents the number of adult deaths and reviews at STHFT during the period 1st January – 31st March 2021. During this quarter, there has been an increase in the number of deaths (918) compared to Q4 in previous years (768 in 2019/20, 791 in 2018/19 and 867 in 2017/18) which reflects the impact of the Covid-19 pandemic. Historically there are more deaths in the winter quarter, Q4, than in any other quarter. 918/918 (100%) have received an ME review, which is the first quarter in which all deaths have received a ME review.

3. Learning from Deaths Cases Reviewed

Nine 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 Q4 2020/21 is included in a separate report quarterly to the Trust Executive Group.

26 of 918 (2.8%) adult and nine of nine (100%) neonatal deaths occurring in Q4 have been subject to SJR (Table 1). An additional 24 (2.6%) adult cases are awaiting a first review. The pressures of COVID-19 impacted the capacity of the SJR Expert Group which has been a limiting factor for the number of SJRs carried out. New reviewers were appointed in December 2020, and a plan to clear the backlog and ensure adequate reviewer capacity is being developed.

Table 1: Quarterly breakdown of adult reviews

	1st Jan – 31st Mar 2021 (Q4)
Total number of adult deaths at STHFT	918
No. of adult deaths subject to an ME review	918
No. SJRs completed	26
No. SJRs score <3 (poor care)	5
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 (50).

Table 2: Mandatory categories of SJR referrals

	1st Jan – 31st Mar 2021 (Q4)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	5
Learning disabilities or with severe mental illness	17
Learning will inform the provider's existing or planned improvement work	8
Not expected to die (e.g. in relevant elective procedures)	20
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e. Covid-19	0
Total referrals	**50**

In this quarter, 120 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.

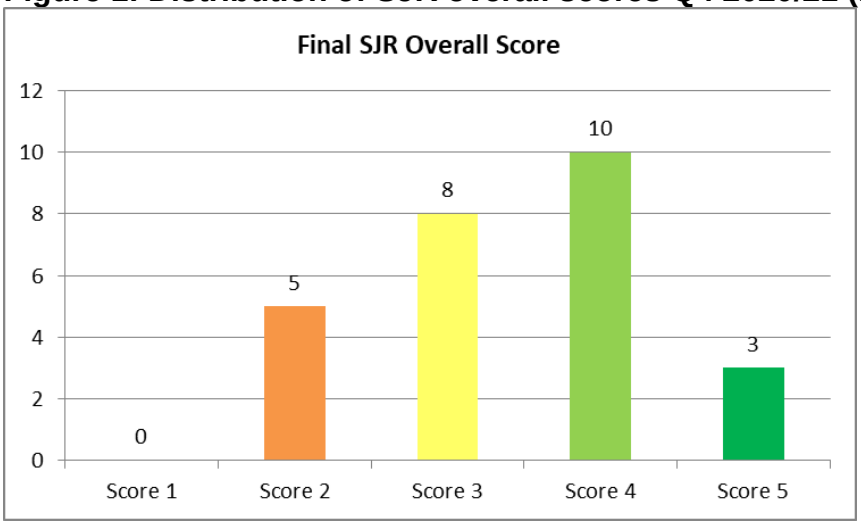
Of the 26 completed adult SJR cases, seven were deaths of patients with a learning disability and three were deaths of patients with a serious mental illness. All 10 cases scored three or greater (good care). Seven cases relating to patients with learning disabilities or severe mental illness are still awaiting a first review. Of the deaths subject to SJR during this period (26), 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 26 adult SJRs completed, five (9%) had a score of less than three, which remained at that level when subject to a second review. All five cases have been referred back to the directorate for responses including relevant clinical context, and will be discussed in the Mortality Governance Committee.

Figure 1 shows the distribution of SJR overall scores for the 26 completed SJRs.

Figure 1: Distribution of SJR overall scores Q4 2020/21 (n=26)



5. Serious Incident Actions

Two deaths were reported as Serious Incidents in this reporting quarter as a result of Structured Judgement Review. One relates to a deteriorating patient with sepsis and the second relates to a delayed transfer to RHH for a patient with sickle cell disease. The outcome of both cases is awaited.

6. Deaths more likely than not due to a problem in care

One case from a previous quarter was judged during Q4 of 2020/21 to be more likely than not due to a problem in care. The patient died in March 2020. They had suffered a number of falls whilst an inpatient and the final fall resulted in a subarachnoid haemorrhage. The case has been to Inquest and the Coroner identified missed opportunities to undertake falls assessments, although it could not be said with certainty that the falls could have been avoided. This was not a formal Regulation 28, although a letter was sent to the Chief Executive. The Coroner was critical of Datix incident forms not being completed following falls, and considered that some of the risk assessments were not fully completed or lacked clarity. An internal investigation found that there were missing falls risk assessments and that moving and handling forms were not completed. The conclusion was that the patient most likely tripped when getting out of bed and it was unclear whether the patient's walking frame had been within reach. A Trustwide programme of audit of the Falls Management Policy was commenced in September 2021 and will continue until March 2022. Improving the assessment and care provided to those at the highest risk of in-patient falls has been selected as one of the Trust Quality Objectives for 2021/22.

7. Regulation 28 Notifications and Prevention of Future Deaths

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

8. Learning from Mortality Analysis

a) Actions arising from SJR scores less than three

The Mortality Governance Committee has identified issues relating to the transfer of patients from an outpatient clinic to the Emergency Department where there was insufficient capacity. As a result, the document '*Professional Standards between Specialties and Emergency Medicine*' was updated and circulated to Clinical Directors. A risk assessment has been completed regarding activity and capacity and is monitored on a daily basis.

A Trustwide audit of bridging protocol processes has been initiated as a result of one case where a patient was not on a bridging protocol prior to a procedure.

Following a number of cases reviewed by Mortality Governance Committee where issues relating to DNACPR were highlighted, a Trustwide audit has been initiated to review the completion of DNACPR forms and recording of discussions in patient's records.

b) Themes identified by SJR and Mortality Governance Committee

Mortality Governance Committee reviews SJR cases scoring less than three with directorate context, feedback and action plans, and emerging themes for improvement are fed back to directorates.

A recurring theme of oxygen management has been referred to the Medical Gases Committee for action. Issues in relation to the completion of fluid balance charts and nursing documentation have been escalated to the Deputy Chief Nurse for action.

c) Review of Directorate Mortality & Morbidity (M&M) Meetings

In 2019, a 360 Assurance audit of Learning from Deaths was undertaken. This highlighted inconsistencies within directorates about how they manage and disseminate learning from deaths. In response to this, a review of M&M meetings was undertaken in Autumn 2020 to establish governance processes relating to mortality in place within directorates.

Key findings:

- Generally positive assurance that M&M is being discussed at a local level, although some inconsistencies included:
  - which deaths are discussed
  - format and recording of meetings
- Gaps in some governance structures regarding accountability for M&M
- No link to the Mortality Governance Committee for mortality reporting and escalation of issues

An action plan has been put in place, including:

- Every directorate/specialty to have a named M&M Lead.
- A Best Practice Guide has been developed and includes roles and responsibilities of M&M Leads and meeting templates.
- M&M updates have been added to the Mortality Governance Committee Work Plan for 2021/22, where any issues or themes should be escalated.
- An audit of M&M meetings to be undertaken in winter 2021.

M&M Leads have been invited to attend the Mortality Governance Committee on a rotational basis.

d) LeDeR Annual Report Key Points

The Sheffield LeDeR Annual Report was published in July 2021 and highlighted the following key points:

- A national publication on COVID-19 deaths of people identified as having learning disabilities indicated a death rate 4.1 times higher than the general population after adjusting for other factors such as age and sex (451 per 100,000 people). However, as deaths in people with learning disabilities are often not registered on databases the researchers estimated the true rate to be up to 6.3 times higher at 692 per 100,000. National data has also highlighted that the death rate for those aged 18 to 34 with learning disabilities is 30 times higher than the same age group without disabilities. There was also a disproportionate impact on people with learning disabilities from Black, Asian and Minority Ethnic backgrounds.

- Based on data from the reviews in Sheffield that were completed between April 2020 and March 2021, 25% of deaths (nine deaths) reported through LeDeR were deemed due to COVID-19. Sheffield health data shows that the COVID-19 share of deaths for all causes for the total population was 20.06% (April 2020 – March 2021).

- Nationally, the NHS has worked with stakeholders, including bereaved families, people with a learning disability and autistic people over the past 12 months to update and develop a new policy which will focus not only on completing reviews but on ensuring that local health and social care systems implement actions at a local level to improve and save lives. The new policy, which looks at the life of a person as well as their death, will also now extend to include all people who are autistic and who do not have learning disability.

- In Sheffield during 2020/21, 70 deaths were notified to the LeDeR programme (this includes 38 reviews, six duplicate reviewers and 26 active reviews). Of the active and completed cases, three were child deaths aged 6, 9 and 14 years. There were 41 actual deaths in the reporting period. The median age of death as 59 years and 29% of total deaths were within the 55-64 age range. The number of male and female deaths was relatively comparable (51.5% male, 48.5% female). The median age of death for males was 58 and for females 59. The majority of deaths (58%) occurred when people were in hospital.

- In the reporting period covered by this study, 86% of people in Sheffield with a learning disability on an end of life care pathway and expected to die had a DNACPR order in place at the time of death. Nationally, concerns have been raised about inappropriate use of DNACPRs for people with learning disabilities.

- The grading of quality of care was rated satisfactory and above for 58% of cases in Sheffield, with the majority being satisfactory. It is important to note that 42% fell short of satisfactory practice. Where care fell short of satisfactory, 20% were deemed to have had an adverse effect on the individual. Lessons learned have formed part of the citywide action plan.

Key themes identified in 2020/21:

1. Care co-ordination across health and social care providers
2. Safeguarding
3. Recognising the deteriorating patient
4. Access to health specialists and follow-up
5. Funding decisions
6. Blood tests
7. Health passports
8. Dysphagia and posture management
9. Oral healthcare
10. Annual health checks
11. Antipsychotic medication/STOMP
12. Access to generic screening
13. Application and documentation of the Mental Capacity Act (MCA)

- There are several projects across the Integrated Care System (ICS) to address the health inequalities that our learning disability and autism population face, including the LeDeR ECHO project, ECHO training and SAMI/RESTORE 2 Mini Tool project, Big Health Days, 'Spreading the News', information sheets, increasing the uptake of flu vaccinations, Health Check work, GP training and a NHSE Masterclass 'Coping with COVID'.

- A Strategic Action Plan has been developed for Sheffield for 2021-2024.

- An evaluation of learning disability deaths is being undertaken by Sheffield Teaching Hospitals, Sheffield Health and Social Care Trust and the Sheffield Clinical Commissioning Group. The aim is to ascertain whether patients with a learning disability were treated equally to patients with no identified learning disability, pre-and post-pandemic. The results will be shared in a future report.