Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Trust Board of Directors

Being Held on 24th May 2022

Subject	Learning from Deaths Report – Q2 2021/22 (1st July – 30th Sept 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 Q2 of 2021/22 (1st July – 30th Sept 2021).

KEY POINTS

The Learning from Deaths Report considers deaths at STHFT in the period 1st July – 30th Sept 2021 as follows:

- Total no. deaths at STHFT: 652 (643 + 9 neonatal)
- Total no. deaths subject to Structured Judgment Review (SJR): 38 (29 + 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

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **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	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Trust Board of Directors is requested to approve the content of the report.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	6th April 2022	Y
Quality Committee	19th April 2022	Y
Trust Board of Directors	25th May 2022	

[1]Status: A = Approval, A* = Approval & Requiring Board Approval, D = Debate, N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Learning from Deaths Report

Q2 2021/22 (1st July – 30th Sept 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 and will be reported at a future date.

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.

2. STHFT Medical Examiner System

During Q2 of 2021/22 Medical Examiner Officer (MEO) staffing increased to 2.8 whole time equivalents (WTE), broadly in-line with the recommended 2.9 WTE advised by NHS England and NHS Improvement for a Trust with approximately 2,900 deaths. This report covers a period of optimal Medical Examiner (ME) staffing (1.05 WTE which includes 0.08 WTE to administer the SJR process).

Table 1 presents the number of adult deaths and reviews at STHFT during the period 1st July – 30th September 2021. During this quarter, there has been an increase in the number of adult deaths (643) compared with Q2 in 2020/21 (458) and a similar number of adult deaths compared with previous years (610 in 2019/20, 666 in 2018/19 and 647 in 2017/18). 643/643 (100%) 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.

The breakdown of adult reviews is shown in Table 1. 29 of 643 (4.5%) adult and nine of nine (100%) neonatal deaths occurring in Q2 have been subject to SJR. Two adult cases are still awaiting a first review due to the unavailability of clinical case notes and one case was rejected as there were no case notes to review (this case was an unexpected death and is currently with the coroner). Table 2 shows these 32 adult cases within the mandatory categories of referral for SJR.

Table 1: Quarterly breakdown of adult reviews

	1st Jul – 30th Sept 2021 (Q2)
Total number of adult deaths at STHFT	643
No. of adult deaths subject to an ME review	643
No. SJRs completed	29
No. SJRs score <3 (poor care)	0
Of the deaths subject to SJR, no. deaths judged more likely than not to be due to a problem in care	0

Table 2: Mandatory categories of SJR referrals

	1st Jul – 30th Sept 2021 (Q2)
Bereaved families and carers, or staff, have raised significant concerns about the quality of care provision	2
Learning disabilities or with severe mental illness	13
Learning will inform the provider's existing or planned improvement work	13
Not expected to die (e.g., in relevant elective procedures)	3
Service specialty, particular diagnosis or treatment group where an 'alarm' has been raised, i.e., COVID-19	1
Total referrals	**32**

In this quarter, 98 adult cases were notified to the coroner after scrutiny by a 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.

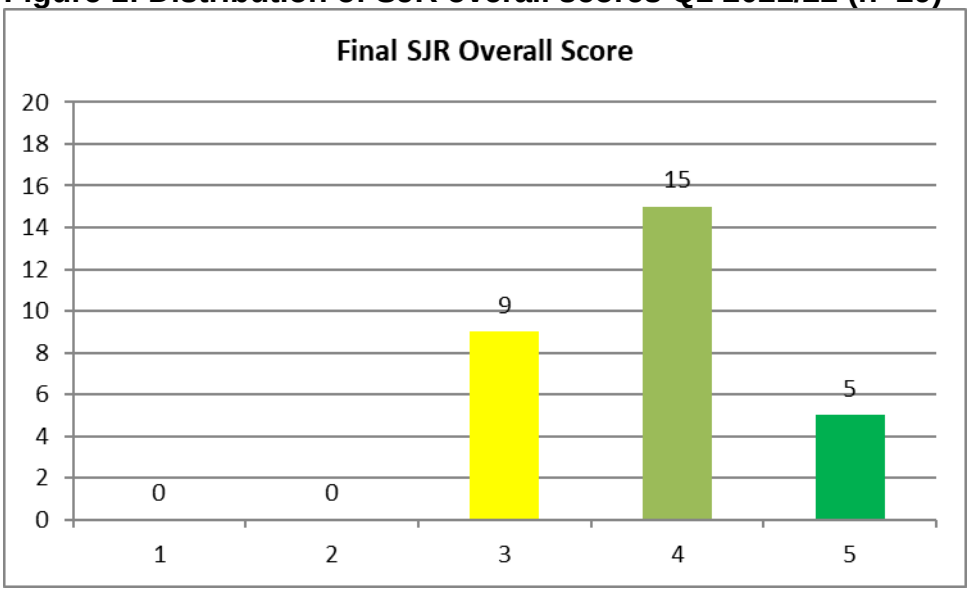
Of the 29 completed adult SJR cases, seven were deaths of patients with a learning disability and four were deaths of patients with a serious mental illness. One patient had both a learning disability and a mental illness. All 12 cases scored three or greater (good care). One case relating to a patient with a learning disability or severe mental illness is still awaiting a first review. Of the 29 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 29 adult SJRs completed, none (0%) had a score of less than three.

Figure 1 shows the distribution of SJR overall scores for the 29 completed SJRs.

Figure 1: Distribution of SJR overall scores Q2 2021/22 (n=29)



5. Cases scoring less than three in previous quarters

One case scored less than three in Q1 2021/22 with an overall outcome of 'poor care' and this has been escalated to the Mortality Governance Committee. The key learning from this case is described in section 6.

Six cases in Q4 2020/21 scored less than three with an overall outcome of 'poor care'. Learning has been reported in Q1 from three of these cases and further learning is included in Section 6 below. The final SI report is awaited for one case and one case is awaiting a directorate response.

6. Learning points and actions from SJR scores less than three

- Importance of completing all fields on DNACPR form and recording discussions with patient and family. The Trust wide DNACPR Audit has also highlighted the need for these improvements and is being shared with clinical teams via directorate triumvirates and Safety and Risk Committee.
- Importance of recording discussions with families in medical notes.
- Importance of documenting date and time of post take ward round.
- Ensuring that Haematology department is informed when a patient with sickle cell disease is admitted.

7. Serious Incident Actions

Three adult deaths were reported as Serious Incidents in this reporting quarter:

- Patient died on ward awaiting emergency vascular surgery. The SI investigation is complete and identified some care issues. The SI has now been referred to the coroner and the conclusion is awaited.
- Patient had an unwitnessed fall whilst on the ward and sustained a head injury. There is a linked complaint and a Coroner's Inquest. To be discussed at SI Group whether death more likely than not due to a problem in care when the investigation has been completed.
- Patient died on transfer to ward from A&E. Concerns about handover in ED and delayed identification of a heart attack resulting in delayed treatment.

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

No cases during Q2 of 2021/22 were judged to be more likely than not due to a problem in care.

9. Regulation 28 Notifications and Prevention of Future Deaths

One Regulation 28 report was received during July 2021 relating to the care of a patient who was admitted to the Royal Hallamshire Hospital on 10 April 2019 for a surgical procedure for cancer of the tongue. The patient suffered a hypoxic brain injury and died on 26 April 2019. This case had been reported as an SI in May 2020. The Regulation 28 identified areas of concern and further actions required in relation to:

- The Trust's standard procedure for referring matters of concern to professional bodies.
- How the Trust's standard process is affected by coronial or other proceedings.

The Trust responded to the coroner providing assurance that there are robust processes in place regarding the referral of professionals to regulatory bodies. It was also confirmed that whilst this process is not dependent on coronial proceedings, any new evidence which is revealed at inquest, or instances where an individual is criticised by the coroner, may have implications for registration which were not previously recognised. In these cases, decisions regarding referral will be revisited.

Regulation 28 reports closed

One regulation 28 report was closed during July 2021 following receipt of a Regulation 28 report in May 2021. The further actions requested by HM Coroner related to knowledge, understanding and application of the Mental Capacity Act 2005 (specifically in relation to senior clinicians) and application of Deprivation of Liberty Safeguards (DoLS), the use of best interest meetings, and the use of hospital passports for patients with learning disabilities. The Trust response and actions taken included:

- Improving knowledge, understanding and application of the Mental Capacity Act (MCA) 2005 (specifically in relation to senior clinicians) and Deprivation of Liberty Safeguards (DoLS).
- Training in relation to the MCA and DoLS made mandatory job specific essential training for all relevant patient facing clinical staff.
- Provision of easy to access documents to support on-going awareness and delivery in practice.
- Provision of additional training and workshops tailored specifically for groups of senior clinicians.
- Development and agreement of an MCA communication and awareness strategy.
- Training to be evaluated with pre and post training assessment to demonstrate increased knowledge.
- A programme of audits developed and commenced to examine application of legislation in practice, the application and recording of MCA and the use of best interest decision making processes to ensure that individuals who lack capacity are supported to influence decisions about their own care.
- Training to ensure that staff are aware of the importance of including family/advocates in these processes.

- Re-launch of the hospital / health passport for patients with learning disabilities to be undertaken as part of the MCA communication strategy.
- Learning Disability intranet site to be updated to include visibility and accessibility of the passport.
- Programme of audits to include use of the health passport.

10. Learning Disabilities / COVID Evaluation of SJR Outcomes

A local evaluation of SJR outcomes was undertaken reviewing three cohorts of patients: pre-pandemic deaths, deaths of patients with COVID during the pandemic and deaths of patients without COVID during the pandemic. All three groups included patients with and without learning disabilities.

The aim was to ascertain whether patients with a learning disability were treated equally to patients with no learning disability, before and during the pandemic. Although numbers were small, and results should therefore be treated with caution, some key points were highlighted as follows:

- Limited visiting by relatives/carers of patients with learning disabilities resulted in poor communication although learning disability was / is an exception to the COVID visiting restrictions.
- Care of patients with a learning disability who had COVID in this sample was poorer than those without a learning disability, which is consistent with national reports.
- Care of patients with COVID in this sample was better than for those without COVID for both learning disability and non- learning disability patients.
- There was a need to raise awareness of the Hospital Passport and the support needs for learning disability patients.

The report was reviewed by the Mortality Governance Committee and shared with the Mental Health Steering Group for discussion at the meeting of 25 April 2022. It was also shared with the citywide Learning Disabilities Group to enable further work to be done in the community, Sheffield Care Trust and LeDeR.

Deaths of patients with learning disabilities continue to be monitored via the SJR and LeDeR programmes and issues highlighted and addressed. Improving the care of patients with learning disabilities in the Trust has been selected as one of the quality objectives for 2022/23.