NHS
The Leeds Teaching Hospitals
NHS Trust

Q3 2020/21 Quarterly Report on Learning from Deaths

Public Board
20 May 2021

Presented for:	Information and Assurance
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Previous Committees:	Mortality Improvement Group

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	
A centre for excellence for research, education and innovation	
Seamless integrated care across organisational boundaries	
Financial sustainability	

Key points/Purpose	
This is the Quarter 3 report for 2020/21 Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
There were five deaths in Q3 2020/21 that have been categorised as potentially avoidable and subject to formal incident investigations.	Information
The Trust Board is asked to note the action taken in response to the COVID-19 pandemic.	Information

1. Purpose

The purpose of this paper is to provide assurance that the Trust has appropriate processes in place to report on and review patient deaths and ensure that lessons are being learned and improvements outlined.

2. Background

National Guidance was published by the National Quality Board in March 2017 entitled “A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”; this guidance was presented to the Quality Assurance Committee in April 2017. In light of this guidance and the previous work of the Mortality Improvement Group, the Trust launched an updated Mortality Review Procedure in June 2017.

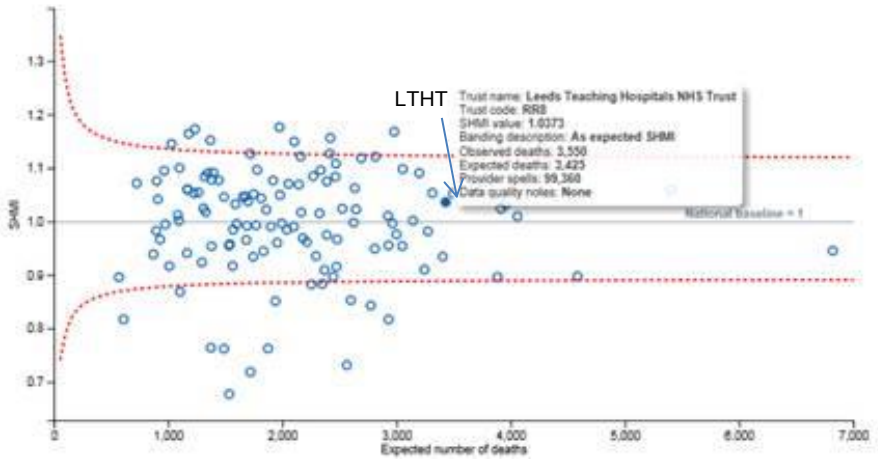
3. Review of National Mortality Indicators

Table 1: National Indicators

SHMI	HSMR (all diagnoses)
1.0373 (Nov-19 to Oct-20)	106.8 (Sep-19 to Aug-20)

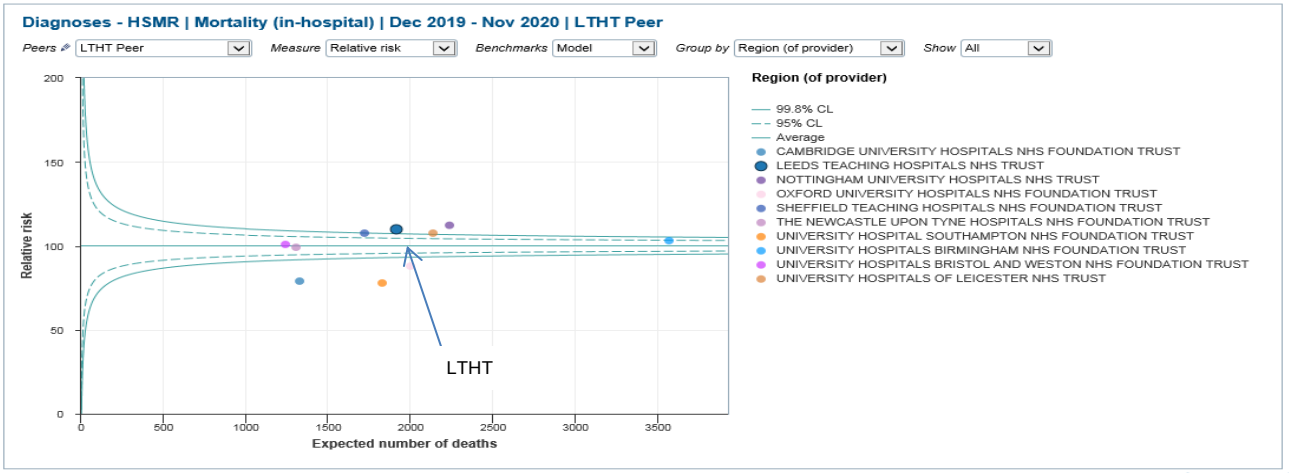
The March 2021 SHMI publication for the period November 2019 to October 2020 is 1.0373 (following progressive reductions since 1.1013 in March 2020), and continues to be ‘as expected’ for both LGI and SJUH sites (other sites do not have sufficient numbers of deaths to be included). Increased Mortality rates during January to March 2018 resulted in a rise in the Trusts SHMI. The measures used in the national mortality models are not adjusted to consider acuity of patients, this may impact on observed deaths in the Trust. Compared to peer organisations LTHT has a lower expected death rate, this is being investigated by the Mortality Improvement Group and a number of actions outlined.

Figure 1.0 SHMI: Leeds VS Peers (Nov-19 to Oct-20)



NB- COVID19 excluded from SHMI

Figure 2.0 LTHT 'Remodelled HSMR' VS Peers (Dec-19 to Nov-20)



4. Update on Mortality Review Process

The National Guidance on Deaths in Care released in March 2017 requires that all Trusts collate and publish specified mortality information on a quarterly basis; within LTHT this included the screening of deaths process.

4.1 Number of Deaths Eligible for Screening and compliance

Table 2: Number of Deaths Eligible for Screening as of 11 March 2021

CSU	Number of Deaths Eligible for Screening Q3 2020/21	Number Screened Q3 2020/21
Emergency and Specialty Medicine	411	411
Cardio-Respiratory	237	237
Abdominal Medicine and Surgery	89	89
Centre for Neurosciences	86	86
Oncology	75	75
Trauma and Related Services	42	42
Women's	5	5
Head and Neck	4	4
Chapel Allerton Hospital	4	4

Figure 4.0: Trust wide Screening Compliance

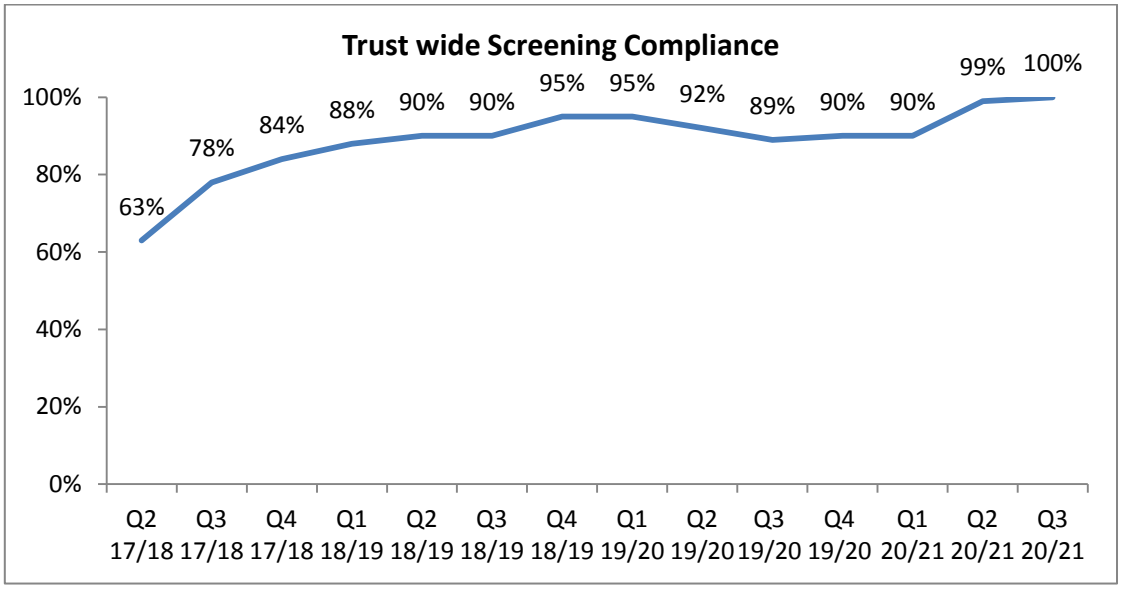
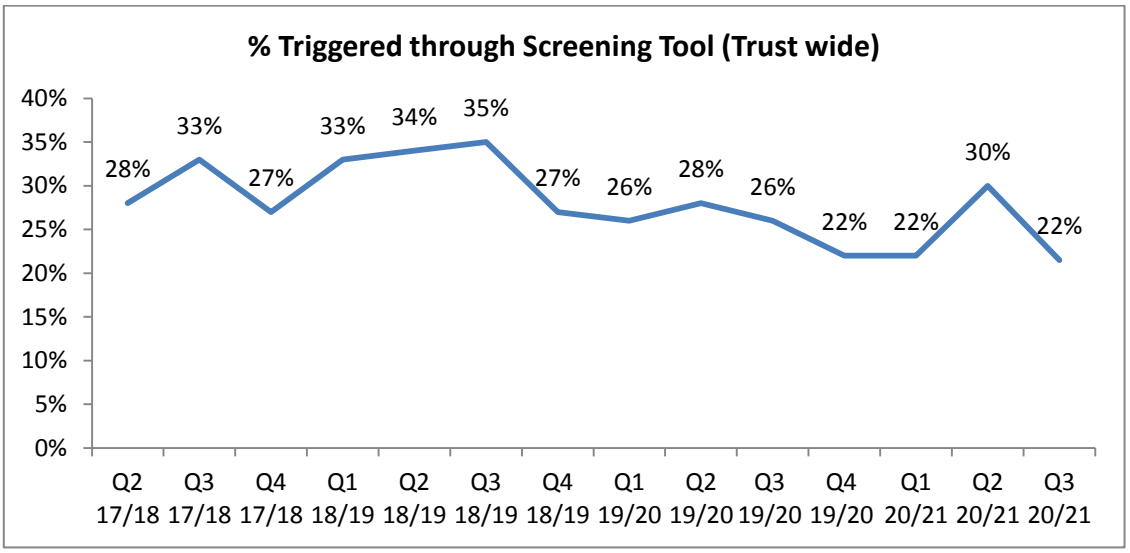


Figure 5.0: Percentage of Reviews Triggered from Screening process



In relation to COVID-19 related deaths, the requirement for screening and completion of SJR's are required in line with the processes outlined above. The escalation process for concerns identified following completion of a clinical review would still be followed, with cases being submitted to the weekly Friday Quality Meeting for further consideration and action.

4.2 Completion of Clinical Reviews

In response to the COVID-19 pandemic and in line with the national guidance, completion of routine mortality and morbidity reviews were suspended in April 2020. The routine mortality review processes were resumed in June 2020, and suspended again in November 2020. The Trust outlined that the mortality screening tool would be completed for all inpatient deaths on PPM+ with clinical specialties completing this in conjunction with the Medical Certificate of Cause of Death (MCCD).

It was agreed that a clinical review (SJR/Clinical record review) would be required if **'Yes'** was documented in response to the following questions;

- *Are you concerned that any problems in healthcare occurred?*
- *Have you any concerns that this death was avoidable?*
- *Is this case subject to an investigation?*
- *Did the Family / carers have any significant concerns regarding the quality of care provided?*

179 clinical reviews were undertaken during Q3 2020/21; there is currently no central location to store completed structured judgment review; an electronic solution is being investigated. Therefore, there may be additional SJRs and reviews being undertaken by CSUs that have not been noted centrally, and the completion figures may be more positive.

5. Potentially Avoidable Deaths Quarter 3

The Trust is required to report quarterly on the number of deaths that are considered to have been "potentially avoidable". These deaths are identified via the weekly Quality meetings where any aspect of the patient's care might have been improved and will be subject to a formal incident investigation.

This report includes all information obtained from Datix in Quarter 3 2020/21 from 01/10/2020 up to and including 31/12/2020. In the reporting period there have been five deaths escalated via the incident reporting system that potentially could have resulted from problems in healthcare and therefore potentially avoidable; these are all subject to formal incident investigations. All five deaths were referred to the Coroner.

Table 3. Potentially avoidable deaths as identified via the incident escalation function - Quarter 3 2020/21

Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	**Q3 20/21**
9	6	3	4	5	3	3	**5**

During Q3 2020/21 one serious incident investigation (level 3) and two internal HCAI RCA investigations were concluded; the root cause and lessons learned were identified and shared in line with the requirements of the NHS Serious Incident Framework and the Trust's Investigations Procedure in order to learn lessons from the reported events.

6. Lessons Learned

Identification of good practice and areas for improvement in care following a patient's deaths are an integral element of the mortality process within LTHT; this is inclusive of potentially avoidable deaths and learning identified following an investigation and learning outlined following a case record review/SJR.

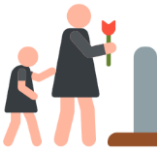
Table 4: Trends in Relation to Good Practice

Escalation
A common theme highlighted was good practice in regards to escalation, including; early planning of escalation discussions, consultant level communication with MDT, patient and families for escalation decisions, and establishing clear goals for escalation.

Multidisciplinary Working
Cross-specialty collaboration was a frequent theme highlighted, with excellent communication between teams and a considered and extensive multidisciplinary approach taken for best clinical care.

Senior Level Led Care
Multiple specialties noted early Senior level led care, including; early consultant led care and regular consultant input, regular daily consultant led ward rounds, consultant level communication with MDT, patient and families for escalation decisions, and prompt and appropriate emergency care from Vascular, ICU, Cardiology and GI surgeons in the first 24 hours.

Table 5: Trends in relation to areas for improvement



Bereavement Care
The need for a Bereavement follow-up standard operating procedure was recognised within Congenital Cardiac Services, and consideration of extending a support service to grandparents was identified within Leeds Children's Hospital.

Continuity of Care
A lack of continuity due to multiple ward moves was identified, and improvements could be made in documenting the reasons for moves to justify if appropriate.

Timely Communication
The need to ensure early involvement and communication with families was highlighted.

7. Mortality Outlier Alerts

Mortality outlier alerts are reviewed and monitored at the Trust's Mortality Improvement Group. The active outlier alerts are detailed in Table 6.

Table 6: Mortality Outlier Alerts

Alert	Date received	Details of Action Taken	Updated provided to CQC
Complication of device, implant or graft	March 2020	A coding review has been completed. A clinical review is underway, once complete the findings and any associated actions will be presented at the Mortality Improvement Group.	

8. Mortality Work Programme

In Q3 2020/21 the Trust continued improvement work in Clinical Coding and Data Quality, which was having a continual positive impact on the Trust's SHMI and HSMR position. Additionally, an internal review of Learning Disability Patient Deaths in 2019/20 was conducted by the Trust Lead for Disabilities and Autism, and shared at the Mortality Improvement Group.

Work is ongoing to implement a solution for the central storage of SJR's, to enable improved oversight of individual reviews. The Trust also continue to work in collaboration with representatives from Dr Foster to benchmark data, trends and analysis in relation to the mortality rates and national / peer comparatives from the Covid-19 pandemic. Work is ongoing in Q4 2020/21 to implement the new Medical Examiner role within the Trust, which will work in conjunction with a revised Mortality Review process.

9. Recommendations

The Trust Board is asked to note the Learning from Deaths Report Q3 (2020/21), and the progress made in implementing the National Guidance on Learning from Deaths.

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March 2021