The Leeds Teaching Hospitals NHS Trust

Trust Board

Q1 2021/22 Quarterly Report on Learning from Deaths

25 November 2021

Presented for:	Information and Assurance
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Previous Committees:	Quality and Safety Assurance Group: 14 October 2021 Mortality Improvement Group: 27 October 2021 Quality Assurance Committee: 4 November 2021

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	

Trust Risks (Type & Category)				
Level 1 Risk	(✓)	**Level 2 Risks**	**(Risk Appetite Scale)**	**Risk**
Workforce Risk			Choose an item	Choose an item.
Operational Risk			Choose an item	Choose an item.
Clinical Risk	✓	Patient Safety and Outcomes	Minimal	↔ (same)
Financial Risk			Choose an item	Choose an item.
External Risk			Choose an item	Choose an item.

Key points/Purpose	
This is the Quarter 1 report for 2021/22 Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
There were 5 deaths in Q1 2021/22 that have been categorised as potentially avoidable and subject to formal incident investigations.	Information
There were no deaths linked to hospital acquired Covid-19 in the Q1 2021/22 reporting period.	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. The Learning from Deaths process is under review in 2021 and will be updated to include the role of the Medical Examiner, and a revised Structured Judgment Review management and monitoring process.

3. Review of National Mortality Indicators

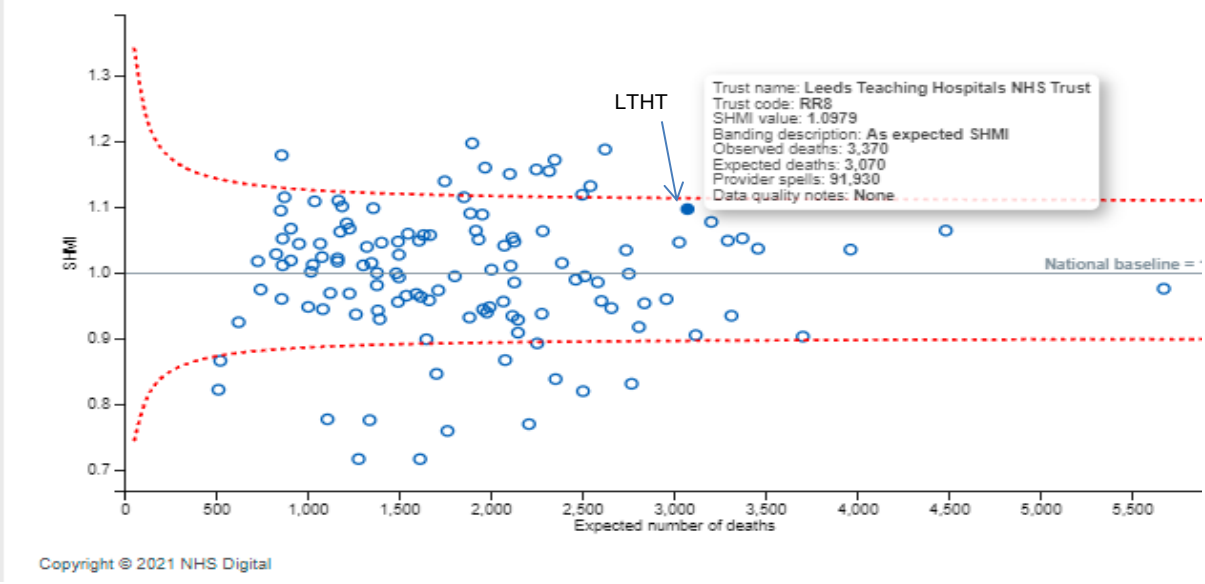
Table 1: National Indicators

SHMI	HSMR (all diagnoses)
1.0979 (Jun-20 to May-21)	109.7 (Jul-20 to Jun-21)

The October 2021 SHMI publication (period June 2020 to May 2021) for the Leeds Teaching Hospitals Trust (LTHT) is 1.0979 ‘as expected’ (up from 1.0962 in September), and continues to be ‘as expected’ for both Leeds General Infirmary (LGI) and St James’ University Hospital (SJUH) sites (other sites do not have sufficient numbers of deaths to be included). Each of the 10 Diagnosis Group level SHMI were banded ‘as expected’.

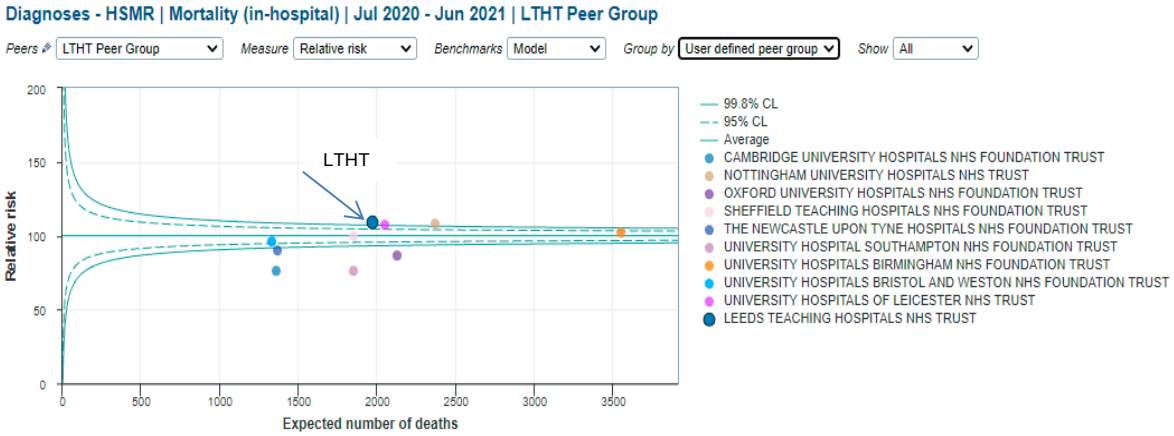
Increased Mortality rates during January to March 2018 resulted in a rise in the Trusts SHMI.
We expect that LTHT would have a higher number of observed deaths than some other organisations due to being a tertiary centre and MTC. Expected deaths do not account for patient acuity and instead is based on diagnostic category, which may have an impact on having a lower expected rate despite treating particularly unwell patients. Our focus is on clinical structured judgement reviews to determine whether the care we are providing to patients is safe and effective. We continue to undertake coding reviews alongside this process to ensure its quality and accuracy and the accuracy of our Mortality statistics. When a diagnosis group is identified as being an outlier we undertake a coding review and a full case record review. Specialty presentations have been added to the workplan of the Mortality Improvement Group in order to better understand their position and offer support.

Figure 1.0 SHMI: Leeds VS Peers (Jun-20 to May-21)



NB- COVID19 excluded from SHMI

Figure 2.0 LTHT 'Remodelled HSMR' VS Peers (Jul-20 to Jun-21)



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 18 August 2021

CSU	Number of Deaths Eligible for Screening Q1 2021/22	Number Screened Q1 2021/22
Emergency and Specialty	240	240

Medicine		
Cardio-Respiratory	112	112
Abdominal Medicine and Surgery	71	71
Centre for Neurosciences	65	65
Oncology	90	90
Trauma and Related Services	34	34
Head and Neck	4	4
Adult Critical Care	0	0
Chapel Allerton Hospital	0	0
Leeds Children's Hospital	0	0
Women's	0	0

Figure 4.0: Trust wide Screening Compliance

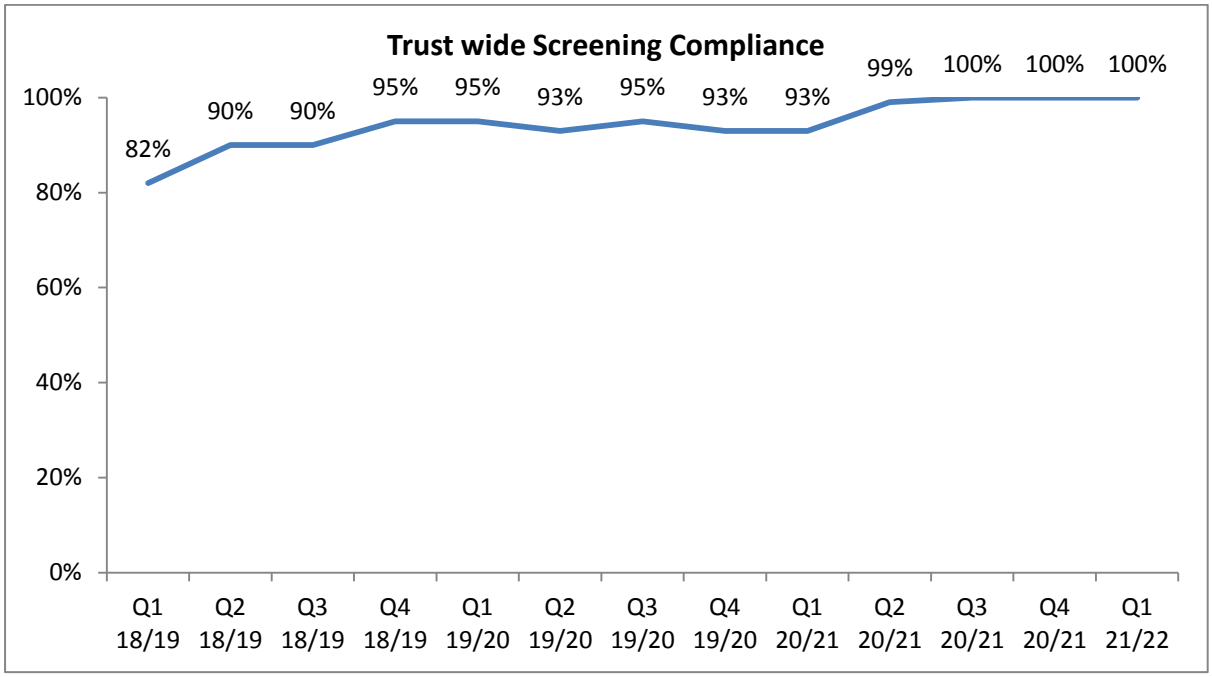
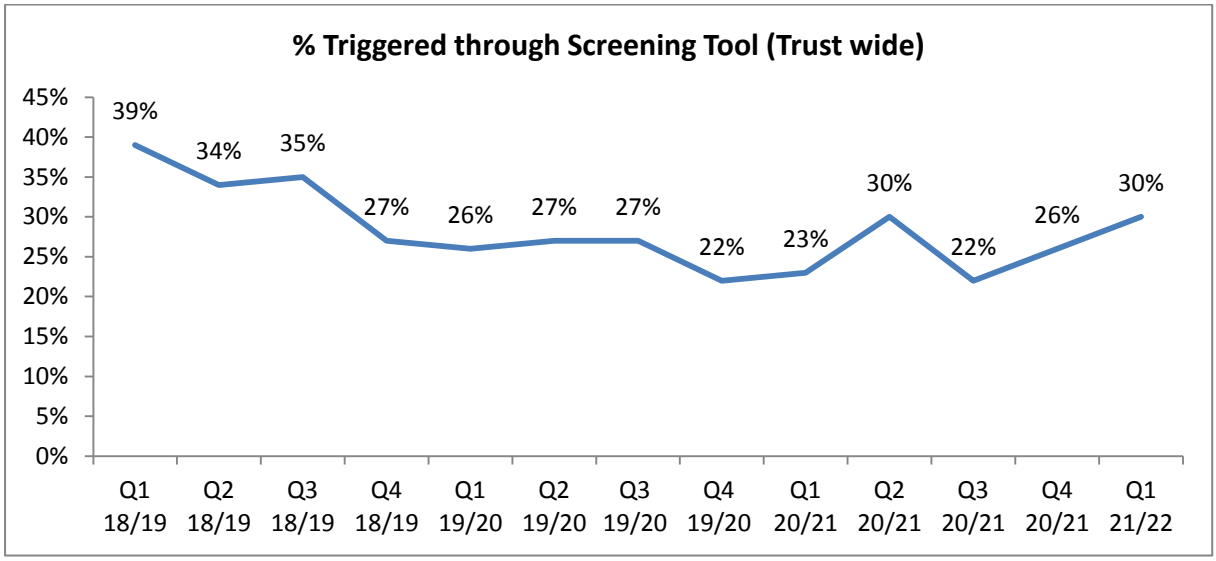


Figure 5.0: Percentage of Reviews Triggered from Screening process



4.2 Completion of Clinical Reviews

252 clinical reviews were undertaken during Q1 2021/22; there is currently no central location to store completed structured judgment review; an electronic solution is being developed. Therefore, there may be additional SJRs and reviews being undertaken by CSUs that have not been noted centrally, and the completion figures may be higher than reported. The system is ready for trial and a pilot specialty identified, however there are information governance issues to resolve with support from DIT.

5. Potentially Avoidable Deaths Quarter 1

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 Trust’s ‘potentially serious incident’ reporting processes and are discussed at the Weekly Quality Meeting where a decision is made on the type and level of investigation required.

This report includes all information obtained from Datix in Quarter 1 2021-22 from 01/04/2021 up to and including 30/06/2021.

In the period: eight deaths were reported and of these five deaths have been identified that possibly could have resulted from problems in healthcare and therefore were potentially avoidable. All these cases are subject to a formal review process. Three of the investigations are still on-going at the time of writing this report. Where the investigations have concluded, the root cause and lessons learned were identified and shared in line with the required processes in order to learn lessons from the reported events. One of the deaths was referred to the Coroner. There were no deaths linked to hospital acquired Covid-19 in the reporting period.

Following receipt of guidance from NHS England for all probable and definite hospital onset healthcare associated Covid-19 infection related deaths to be reported as serious incidents on StEIS, a local procedure was developed and circulated across the Trust in January 2021. The procedure was developed with the involvement of Infection Control; Risk Management; the Patient Safety and Quality Managers and was approved by the Chief Nurse and Chief Medical Officer. NHS England define a probable or definite hospital-onset healthcare associated Covid-19 infection death as:

- The death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or Covid-19 is cited on either Part 1 or Part 2 of the death certificate (i.e. the death resulted from a Covid-19 clinically compatible illness with no period of complete recovery between the illness and death);
- And, the Covid-19 infection linked to the death meets the definition of probable or definite hospital onset healthcare associated infection.

A process was agreed with the Chief Nurse and Chief Medical Officer for all deaths related to hospital onset COVID-19 to be reviewed by the Associate Medical Director (Risk) to determine the impact of COVID-19 on the death, to inform the decision regarding StEIS reporting. All cases would be reviewed weekly and a summary provided to the quality review meeting to agree those deaths that would be reported on StEIS. This process accounts for the rise in the number of deaths reported in Q4 2020/21. There were no deaths linked to hospital acquired Covid-19 in the Q1 2021/22 reporting period.

In instances where a patient has had a positive test result and the swab date was more than 28 days prior to death, this death would not be considered a Covid-19 death unless Covid-19 is cited in part 1 or part 2 of the death certificate.

Table 3. Potentially avoidable deaths as identified via the incident escalation function - Quarter 1 2021/22

Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	**Q1 21/22**
9	6	3	4	5	3	3	5	21*	**5**

*The process implemented for reporting probable and definite hospital onset healthcare associated Covid-19 infection related deaths accounted for the increase in the figure reported for Q4 2020/21, as outlined above.

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

Communication with Families
Good communication and involvement of families/next of kin was frequently highlighted across multiple Specialties, as was clear documentation of these discussions.

End of Life Care
Good practice was identified in End of Life Care, including; use of ReSPECT forms, bereavement support for families, input from the palliative care team and good prescribing practice/symptom control.

Multi-Disciplinary Team Working
Good multi-disciplinary team working was a common theme identified through the Mortality Reviews, including; early and clear inter-departmental communication, excellent acute support and ICU input, and involvement from both the Learning Disability & Autism team and Palliative Care team.

Table 5: Trends in relation to areas for improvement

Continuity of Care
Multiple ward moves were identified as a theme for improvement, this included ensuring that inpatient transfers were appropriate and happened at an appropriate time to ensure continuity of care.

Timely Care
A theme for improvement was timely care, ensuring the right care is given at the right time. This included; ensuring timeliness of testing and administration of antibiotics, implementation of escalation plans and ceiling of care decision making.

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 of these cases was delayed in response to the Covid-19 pandemic but has now resumed, once complete the findings and any associated actions will be presented at the Mortality Improvement Group.	

8. Mortality Work Programme

In Q1 2021/22 work continued with the Perinatal Team and Informatics to develop a new perinatal mortality database, following the external peer review by University Hospitals of Leicester NHS Trust. The Trust continued improvement work in Clinical Coding and Data Quality, and worked in collaboration with representatives from Dr Foster to benchmark data, trends and analysis in relation to mortality rates and national / peer comparatives.

Moving forwards, there has been a shift to focus on understanding our own data further, and to review the format of the Mortality Indicator report to help the Group better understand the relationship between expected death rates and the crude mortality figure. In line with this, specialties will be invited as part of a revised work plan to present on their learning from deaths process and the themes and trends identified. Going forward they will also be supported to understand their own mortality data and to present on this. Additional resource has been identified to support this work.

9. Recommendations

The Mortality Improvement Group is asked to note the Learning from Deaths Report Q1 (2021/22), and the progress made in implementing the National Guidance on Learning from Deaths.

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October 2021