The Leeds Teaching Hospitals NHS Trust

Q3 2021/22 Quarterly Report on Learning from Deaths
Trust Board
26 May 2022

Presented for:	Information and Assurance
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Previous Committees:	Quality Assurance Committee, 28 April 2022

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)**	**Tolerance**
Workforce Risk				
Operational Risk				
Clinical Risk		Patient safety and outcomes: We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	↔ (same)
Financial Risk				

Key points/Purpose	
This is the quarter three 2021/22 report on Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
There were four deaths in Q3 2021/22 that have been categorised as potentially avoidable and subject to formal incident investigations.	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. This was reviewed in 2021 and an updated Mortality Review Policy was approved in January 2022 to include the role of the Medical Examiner, and a revised Structured Judgment Review management and monitoring process.

3. 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. The Trust Mortality Review Policy has been refreshed to outline a revised process for monitoring Mortality Reviews (namely Structured Judgment Reviews) to better enable themes of learning to be identified, and this was approved in January 2022. The new Structured Judgment Review (SJR) allocation process will be coordinated by the Quality Governance Team and will also include cases highlighted for SJR through the Medical Examiners (ME) office; this will commence in Q1 2022/23.

3.1 Number of Deaths Eligible for Screening and compliance

Table 1: Number of Deaths Eligible for Screening as of 12 April 2022.

CSU	Number of Deaths Eligible for Screening Q3 2021/22	Number Screened Q3 2021/22	Number Triggered Q3 2021/22
Specialty & Integrated Medicine	253	253	49
Cardio-Respiratory	192	192	43
Abdominal Medicine and Surgery	96	96	19
Oncology	110	110	12
Centre for Neurosciences	79	79	28

Trauma and Related Services	33	33	22
Head and Neck	5	5	3
Urgent Care	53	53	17
Adult Critical Care	0	0	0
Chapel Allerton Hospital	5	5	0
Leeds Children's Hospital	0	0	0
Women's	1	1	1

Figure 1.0: Trust wide Screening Compliance

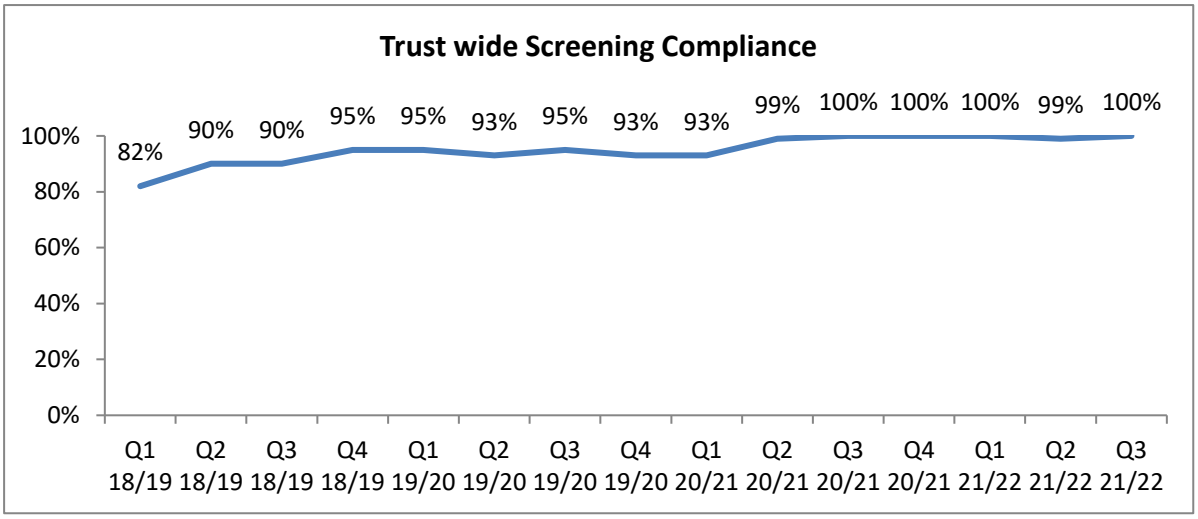
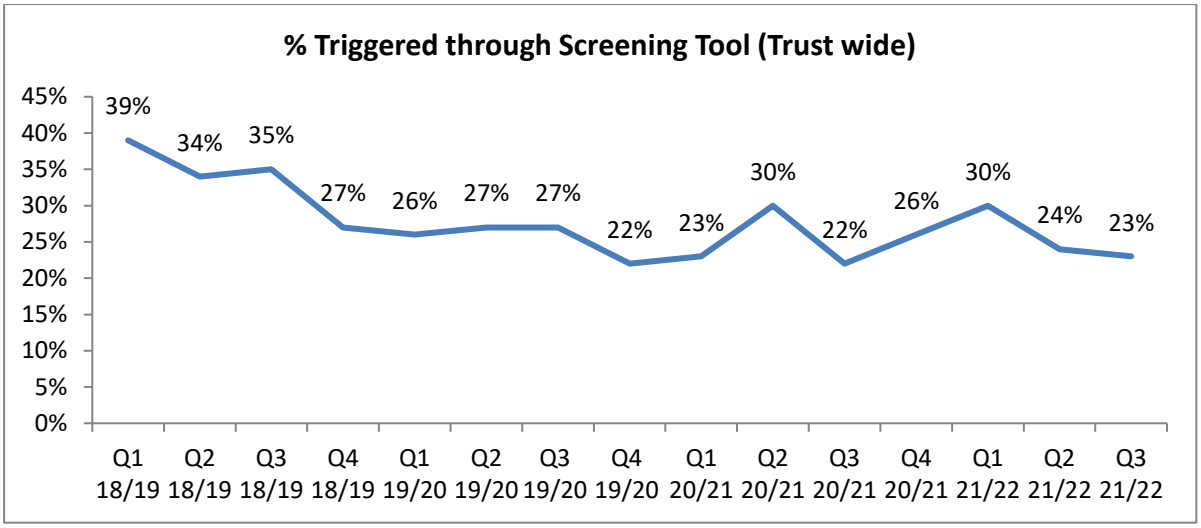


Figure 2.0: Percentage of Reviews Triggered from Screening process



3.2 Completion of Clinical Reviews

To date the Quality Governance Team were notified of 131 mortality reviews (98 SJR) that were completed during Q3 2021/22; there is currently no central location to store completed SJRs, 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. An electronic SJR storage system has been developed by the Trust Leeds Health Pathways team which will better enable completed SJRs to be captured and monitored centrally by the Quality Governance Team. The new system is currently following the approval process outlined by the Trust IT and cyber security teams. Once approved, it will be piloted in select Specialties, with Trust wide implementation following in Q2 22/23. All patient deaths are subject to alternative review methodology in the Leeds Children's Hospital, Emergency Department and the Major Trauma Centre. This approach has been agreed by the Mortality Improvement Group to account for the regulatory and service specific requirements in these areas.

4. 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 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 Three 2021-22 from 01/10/2021 up to and including 31/12/2021.

In the period: seven deaths were reported and of these four 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. One of the investigations is 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.

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 One or Part Two 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.

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 one or part two of the death certificate.

Table 3. Potentially avoidable deaths as identified via the incident escalation function - Quarter 3 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	Q2 21/22	**Q3 21/22**
9	6	3	4	5	3	3	5	21*	5	4	**4**

*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.

Lessons learned from all serious incident investigations are discussed at the Trust Lessons Learned Group.

The Trust has led on the establishment of a shared learning group involving WYATT Trusts. The purpose of this is to set up a network to discuss common challenges relating to quality and safety, focusing on sharing key learning points and themes arising from serious incident and never event investigations, reporting to the WYAAT Medical Directors group.

The network has continued to meet during the COVID-19 pandemic response. Key topics for sharing learning and ideas from across the West Yorkshire region on locally reported serious incidents and Never Events have been discussed, in addition to a review of regular incident reporting profiles through the different stages of the pandemic. The group has also discussed the process for reporting deaths related to COVID-19 to agree an approach that is both consistent and proportionate, involving medical review to determine deaths to be reported on StEIS, which was supported by the WYAAT Medical Directors and Chief Nurses.

The learning from the closed incident investigations are summarised in the themes outlined in section five. The investigations are conducted in accordance with the requirements of the NHS Serious Incident Framework and the Trust's Investigations Procedure with the focus being on learning to avoid a reoccurrence of the incident and not to determine the avoidability of the consequences.

5. 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, as well as learning outlined following a case record review/SJR.

Table 4: Trends in Relation to Good Practice

Multi-Disciplinary Team (MDT) Working
Good cross-specialty team working and collaboration was a common theme identified, with timely MDT-led input and decision making, good communication and support.

Management of Care
There was good practice around management of care identified, including; early care planning, prompt recognition of clinical deterioration, timely medical review, clinical management and assessments, and ascertaining patient capacity needs.

Senior Led Care
Senior-led care was frequently highlighted as an area of good practice, which included; early and comprehensive consultant review, frequent senior involvement, and prompt management.

Table 5: Trends in relation to areas for improvement

Communication
Themes around communication including communication between Trusts when care is shared, the use of interpreters for communication and the challenge around visiting restrictions for family discussions were highlighted as areas for improvement.

Delays
Themes around timeliness were highlighted for improvement, including; delays in discharge and deconditioning, waits in A&E for a specialty bed, ensuring timely antibiotic therapy, and managing delays to step down to ward level care from ICU.

6. Mortality Outlier Alerts

Mortality outlier alerts are reviewed and monitored at the Trust's Mortality Improvement Group (MIG), chaired by the Associate Medical Director (Risk Management). The MIG reports into the Clinical Effectiveness and Outcomes Group, and any safety items for escalation would be discussed at the Quality and Safety Assurance Group. The active outlier alerts are detailed in Table 6.

Table 6: Mortality Outlier Alerts

Alert	Date received	Details of Action Taken
Complication of device, implant or graft	March 2020	A coding review was undertaken in Q1 20/21 prior to the outlier investigation being paused due to the impact of the COVID-19 pandemic. The Mortality Improvement Group are reviewing the data and Trust's relative risk for this diagnosis group and any associated actions will be presented at the Mortality Improvement Group in Q1 22/23.

8. Mortality Work Programme

In Q3 2021/22 the organisation worked to improve understanding of our own data, and members of the Mortality Improvement Group have attended Mortality statistics courses to support this. An internal review of deaths following

paediatric cardiac surgery at LTHT during October 2021 was conducted and the outcomes of this review were presented at the MIG for assurance. Additionally, the Mortality Review Policy was reviewed and updated to reflect the Medical Examiner role and a new SJR allocation process, to improve monitoring of SJR completion and learning themes. An internal audit of the Trust's Mortality Framework was conducted by PwC and the Mortality Improvement Group would review the findings of this and monitor completion of any subsequent actions.

In Q4 2021/22 the new Quality Analyst for Mortality would start in post and would be working with Specialties regarding the implementation of the new SJR allocation process. An investigation into the Trust's SHMI would also take place, including a review of quality of care conducted by the Associate Medical Director of Risk for assurance.

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April 2022