The Leeds Teaching Hospitals NHS Trust

Q2 2021/22 Quarterly Report on Learning from Deaths
Trust Board
31 March 2022

Presented for:	Information and Assurance
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Previous Committees:	Mortality Improvement Group 21 December 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)**	**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 two 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 four deaths in Q2 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. 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. 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 Policy is currently being refreshed to outline a revised process for monitoring Mortality Reviews (namely Structured Judgment Reviews) to better enable themes of learning to be identified.

3.1 Number of Deaths Eligible for Screening and compliance

Table 1: Number of Deaths Eligible for Screening as of 15 December 2021

CSU	Number of Deaths Eligible for Screening Q2 2021/22	Number Screened Q2 2021/22
Specialty & Integrated Medicine	267	264
Cardio-Respiratory	199	199
Abdominal Medicine and Surgery	85	85
Oncology	84	84

Centre for Neurosciences	73	73
Trauma and Related Services	33	32
Head and Neck	2	2
Urgent Care	1	1
Adult Critical Care	0	n/a
Chapel Allerton Hospital	0	n/a
Leeds Children's Hospital	0	n/a
Women's	0	n/a

Figure 1.0: Trust wide Screening Compliance

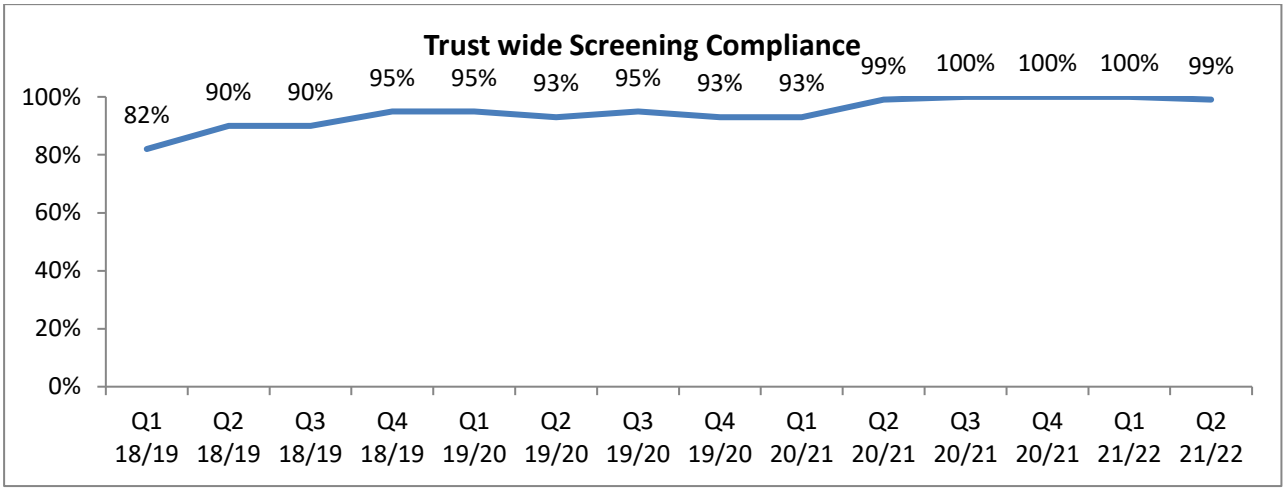
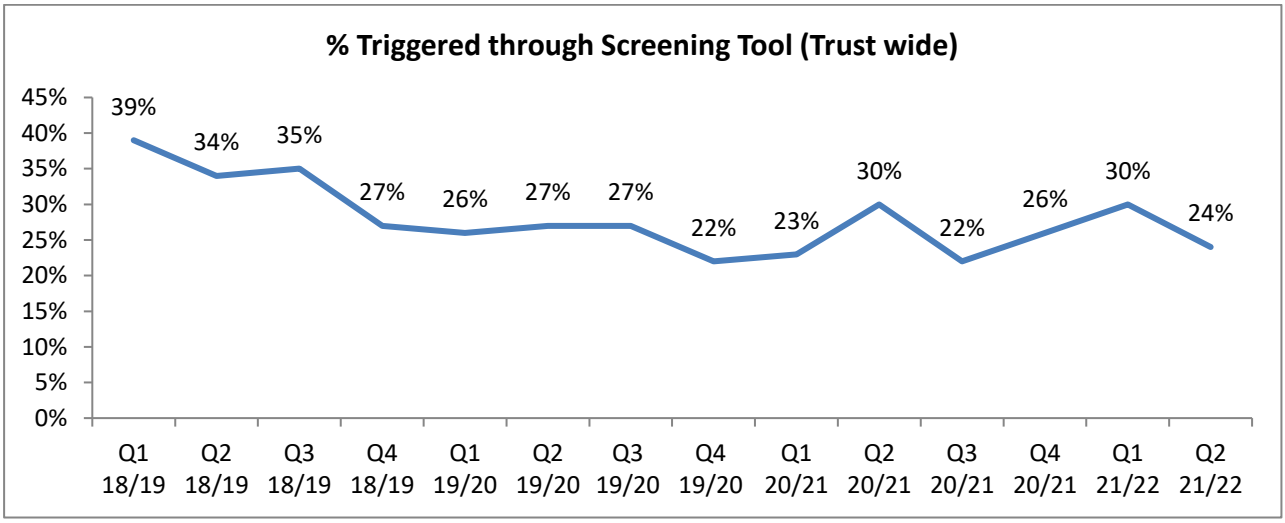


Figure 2.0: Percentage of Reviews Triggered from Screening process



3.2 Completion of Clinical Reviews

183 clinical reviews were undertaken during Q2 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.

4. Potentially Avoidable Deaths Quarter 2

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 two 2021-22 from 01/07/2021 up to and including 30/09/2021.

In the period: six 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 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	**Q2 21/22**
9	6	3	4	5	3	3	5	21*	5	**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.

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 and learning outlined following a case record review/SJR.

Table 4: Trends in Relation to Good Practice

Documentation
Good practice in regards to clear documentation of discussions and clinical events was a frequent theme across multiple Specialties.

Timely Management & Review
Timely management of care was a frequent theme, including; early ceiling of care decision making, timely reviews, assessments, early discussions regarding escalation plans, and prompt involvement of outreach and palliative care teams.

Communication
Good communication was a common theme highlighted by Specialties; this included good communication with families and ensuring their involvement in discussions and decision making, as well as communication between teams, with good multidisciplinary team collaboration.

Table 5: Trends in relation to areas for improvement

Transfer & Discharge
Ensuring documents are available in a timely manner following transfer to avoid delays in discharge, learning regarding fast track discharge and ensuring ward moves are appropriate for continuity of care, were all highlighted by specialties.

Antibiotics & Sepsis
An area for improvement identified from the Mortality reviews in Q2 included ensuring early initiation of antibiotics for sepsis, as well as theatre prioritisation for septic patients.

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	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 Q2 2021/22 the Coding Team conducted a review of a sample of patients to determine whether the correct ventilation codes were being used, and the findings and recommendations were reviewed by the Mortality Improvement Group. The Perinatal team also conducted a robust review of the Trust's perinatal mortality data following an alert from Dr Foster, and this was presented to the Quality & Safety Assurance Group in September 2021. During Q2 an SBAR was produced on the Trust's resource for the Mortality

workstream, and resource for a new Analyst post was identified and approved.

In Q3 2021/22 work would continue on finalising the new Mortality Policy to outline a revised process for monitoring SJRs and identifying learning themes.

Learning from Deaths Q2 2021/22
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December 2021