

Learning from Deaths Q3 2022/23

Public Board
25 May 2023

Presented for:	Information and Assurance
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Previous Committees:	Quality Assurance Committee - 20 April 2023

Our Annual Commitments for 2023/24 are:	
Effectively develop and deploy new assets (buildings, equipment, IT)	
Reduce healthcare associated infections	
Improve staff retention	
Deliver the financial plan	
Reduce average length of stay by 0.5 days per patient	
Achieve the Access Targets for Patients	✓
Support a culture of research	✓

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk				
Operational Risk				
Clinical Risk	✓	Patient Safety & Outcomes Risk - 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				
External Risk				

Key points	
1. This is the quarter three 2022/23 report on Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
2. There were six deaths in quarter three 2022/23 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. Review of National Indicators

The March 2023 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12 month rolling period November 2021 to October 2022 for the Leeds Teaching Hospitals NHS Trust (LTHT) is 1.1290 (up from 1.121 in February 2023) and is banded ‘higher than expected’. The SHMI continues to be ‘as expected’ for both Leeds General Infirmary (LGI) and St James’ University Hospital (SJUH) sites when broken down at site level (other sites do not have sufficient numbers of deaths to be included). All ten of the Diagnosis Group level SHMI were banded ‘as expected’ for this reporting period. The Mortality Improvement Group continues to monitor the Ten Diagnosis Group level SHMI.

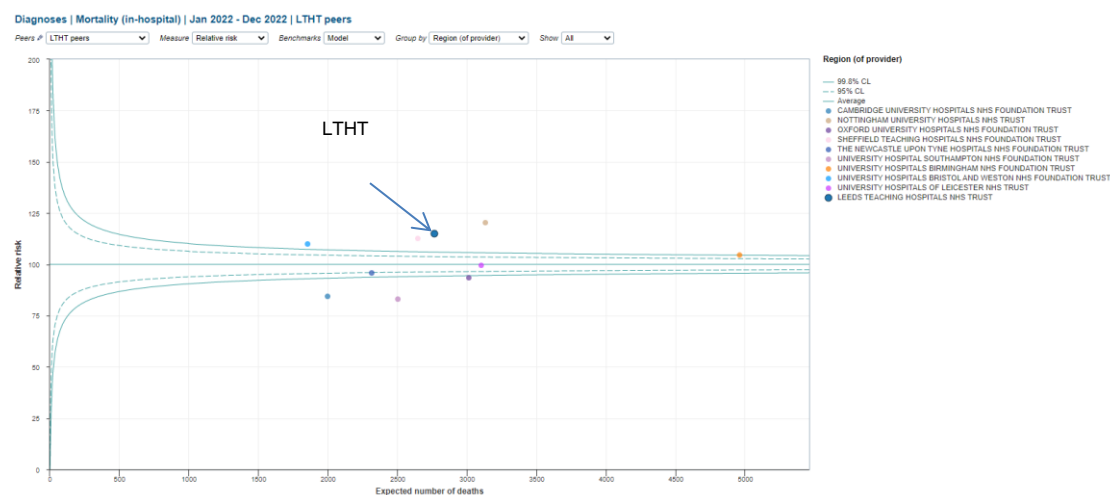
Table 1: National Mortality Indicators

	Figure (Mar-23 Publication)	Banding	Trend
SHMI	1.1290 (Nov-21 to Oct-22)	‘Higher than expected’	↑

HSMR (basket of 56 diagnoses)	114.7 (Jan 22 to Dec-22)	'Higher than expected' 
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We expect that LTHT would have a higher number of observed deaths than some other organisations due to being a tertiary centre and Major Trauma Centre (MTC). Expected deaths do not account for patient acuity and instead are based on diagnostic category, which may have an impact on having a lower expected rate despite treating particularly unwell patients. The Mortality Improvement Group continue to monitor the Trust's Mortality Indicators and will continue to undertake coding reviews alongside this process to ensure its quality and accuracy and the accuracy of our Mortality statistics. Structured Judgement Reviews (SJR) will also be requested and monitored through the new SJR allocation process to provide assurance that the care we are providing is safe and effective.

Figure 1.0 LTHT Dr Foster SMR vs. Peers (Jan-22 to Dec-22)



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. 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 Structured Judgment Review (SJR) allocation process is coordinated by the Quality Governance Team and also includes cases highlighted for SJR through the Medical Examiners (ME) office; this commenced in May 2022.

4.1 Number of Deaths Eligible for Screening and Compliance

Table 2: Number of Deaths Eligible for Screening as of 1 March 2023.

CSU	Number of Deaths Eligible for Screening Q3 2022/23	Number Screened Q3 2022/23	Number Triggered Q3 2022/23
Specialty & Integrated Medicine	270	258	70
Cardio-Respiratory	166	161	45
Oncology	78	68	12
Abdominal Medicine and Surgery	94	93	34
Centre for Neurosciences	86	75	26
Trauma and Related Services	44	38	28
Urgent Care	63	54	16
Head and Neck	1	1	1
Chapel Allerton Hospital	1	1	0
Women's	0	n/a	n/a

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

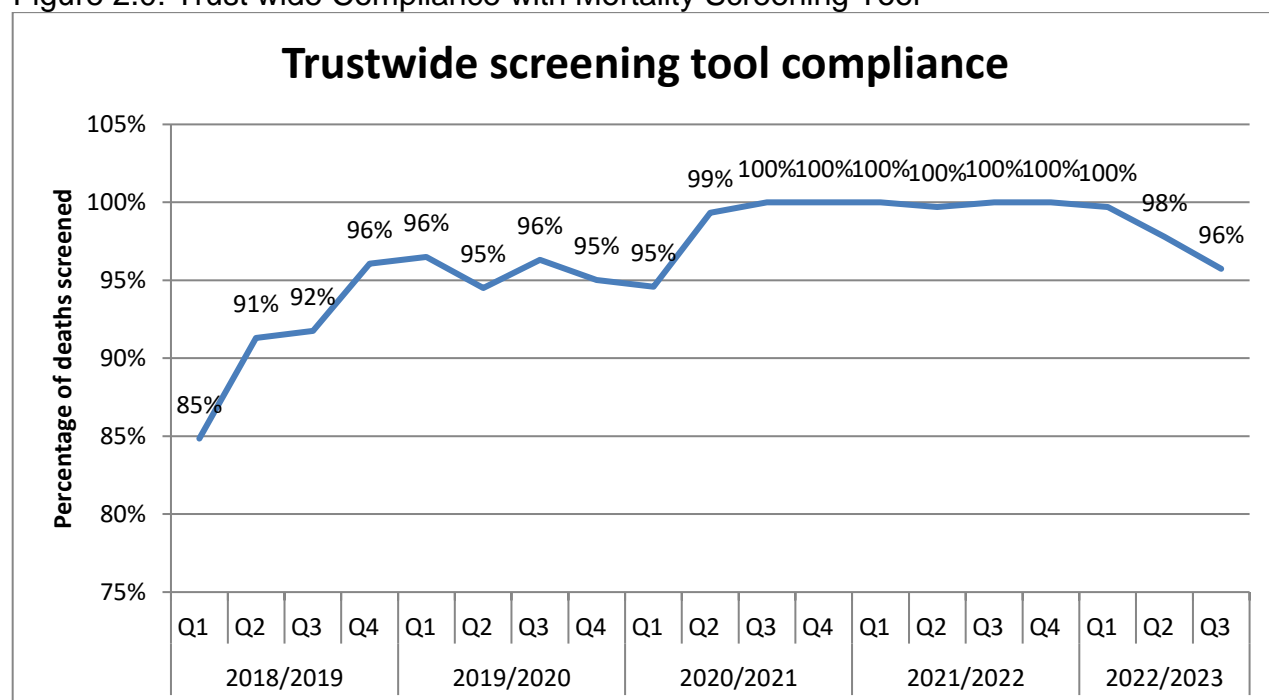
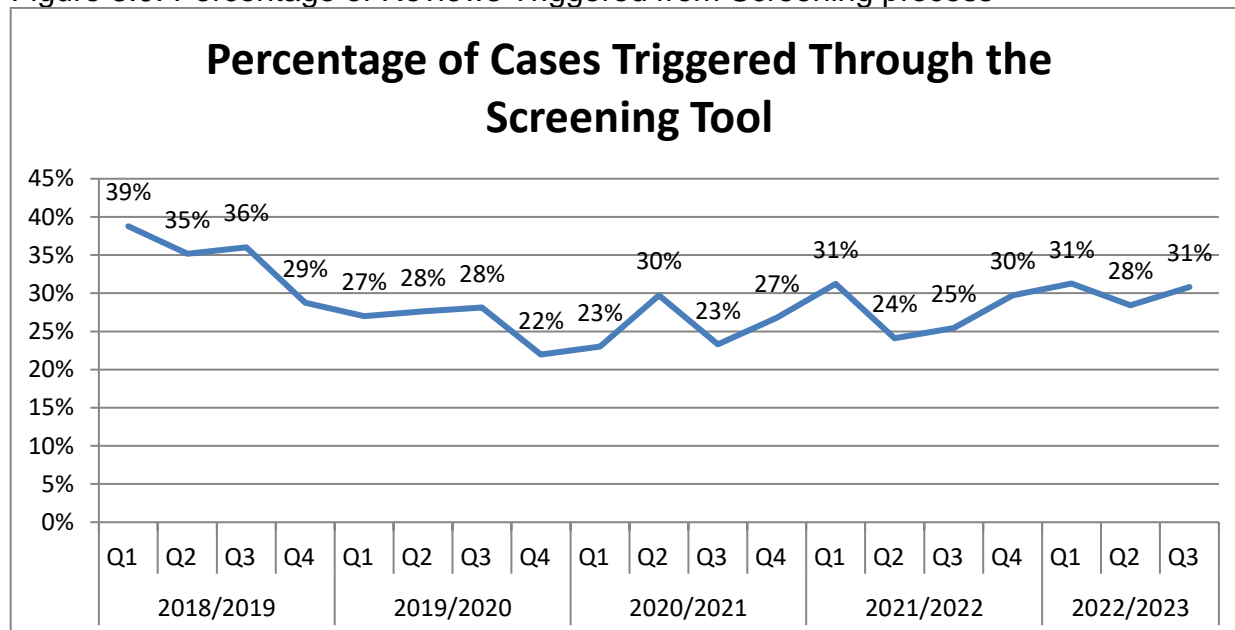


Figure 3.0: Percentage of Reviews Triggered from Screening process



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 182 mortality reviews (all of which were Structured Judgement Reviews (SJR)) that were completed during Q3 2022/23. All patient deaths within Leeds Children's Hospital, Emergency Department and the Major Trauma Centre are subject to alternative review methodology. This approach has been agreed by the Mortality Improvement Group to account for the regulatory and service specific requirements in these areas.

Historically, there has been 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 was piloted in select Specialties in Q3 to gain feedback before Trust wide launch.

5. Potentially Avoidable Deaths - Summary of Investigation and Learning

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 'potential patient safety 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 3 2022-2023 from 01/10/2022 up to and including 31/12/2022.

In the period: twelve deaths were reported and of these six 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. Two of the investigations are still on-going at the time of writing this report. Where the investigations have concluded, the outcome and learning from these are included below. All six deaths were reported to the Coroner.

Table 3 - Potentially avoidable deaths as identified via the incident escalation function - Quarter 3 2022/23 YTD

Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23
5	4	4	6	4	10	6

Table 4 - Details of potentially avoidable deaths identified via the incident escalation function - Quarter 3 2022/23

Quarter 3 2022/23			
ID	Level of Investigation	Category	Additional Information
511841	HCAI RCA PSII 2022/22631	Infection (Hospital Acquired COVID-19)	
513276	HCAI RCA PSII 2022/23194	Infection (Hospital Acquired COVID-19)	
517217	HCAI RCA PSII 2022/22628	Infection (Hospital Acquired COVID-19)	
514531	HCAI RCA PSII 2022/23184	Infection (Hospital Acquired COVID-19)	
519583	PSII 2023/2253	Delay or failure in treatment for infection	Investigation has not yet concluded
520077	PSII 2022/25572	Delay or failure in treatment or procedure	Investigation has not yet concluded

5.1 Lessons Learned from Completed Investigations - Quarter 3 2022/23 YTD

Lessons learned from all Patient Safety Incident investigations are discussed at the Trust Lessons Learned Group.

The Trust has led on the establishment of a shared learning group involving West Yorkshire Association of Acute Trusts (WYAAT). 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 Patient Safety Incident Investigations and Never Events, reporting to the WYAAT Medical Directors group.

Key topics for sharing learning and ideas from across the West Yorkshire region on locally reported Patient Safety Incident Investigations and Never Events have been discussed, in addition to a review of regular incident reporting profiles. 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 completed incident investigations and the learning from these are summarised in the table below. The table shows the details of the root causes and the key lessons learned to address the care and service delivery issues identified during the investigations.

The investigations are conducted in accordance with the requirements of the Patient Safety Incident Response Framework (PSIRF) which was introduced within LTHT at the beginning of April 2022 and replaces the Trust's previous Serious Incident Procedures. This is in line with 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.

Table 5 - Details of completed investigations into potentially avoidable deaths
- Quarter 3 2022/23

Incident	Key findings	Lessons Learned
Covid-19 Probable and Definite Healthcare Associated Deaths	Multifactorial - not possible to establish one factor as root cause but found to be a combination of linked issues.	<ol style="list-style-type: none"> 1. Importance of ensuring furniture/bed spaces are 2 metres apart. 2. Ensuring staff and patients are compliant with PPE especially ensuring patients are reminded to wear face coverings of face masks when mobilising around the ward. 3. Ensuring screening of patients when taking handover from other areas is accurate and Covid screening has been completed as per Trust policy. 4. Ensuring frequent decontamination of equipment and environment and evidencing the same. 5. Ensuring areas/wards are clearly signposted using physical barriers as appropriate to ensure patients/individuals and staff understands the different risk areas. 6. Importance of ensuring compliance with assurance

		<p>principles (Hand Hygiene audits, Covid assurance visits, Covid swab regime).</p> <p>7. Reiterating the need for use of single cleaning/disinfectant wipes.</p> <p>8. Importance of monitoring compliance with lateral flow testing.</p>
<p>500815 - Delay or failure in treatment or procedure</p>	<p>Baby death which was contributed to significantly by the presence of bilateral pneumothoraces, despite the insertion of multiple chest drains the lungs were not able to re-expand properly. This led to a period of prolonged and profound hypoxia. The point at which the pneumothoraces occurred is very difficult to pin point. Around 2% of new born babies will have x-ray evidence of pneumothorax simply as a result of being born. In the large majority of cases this causes no issue.</p> <p>The key points were;</p> <ul style="list-style-type: none"> • A pneumothorax was not excluded prior to Less Invasive Surfactant Administration (LISA) as the protocol was, at that time, not fit for purpose and consultant input had not been sought again in part due to this • The isolation of the unit and delay in consultant presence being requested and arriving meant there was no other paediatric support to break the cycle and ensure pneumothorax was reconsidered having been previously discounted. 	<p>1. The requirement for Consultant input prior to the undertaking of the LISA procedure is now mandatory</p> <p>2. The requirement for a chest x-ray prior to LISA in this age group of babies is now mandatory</p> <p>3. The risk stratification and observation process for babies of this age group on delivery suite requires review</p> <p>4. The process relating to documentation of paediatric input at delivery needs clarification</p> <p>5. The hypoglycemia protocol as it relates to this age group of babies needs clarification with a focus on highlighting what should be achieved within a baby's first hour of life.</p> <p>6. The on call arrangements as they relate to consultant cover at SJUH need review</p> <p>7. Undertaking of the LISA procedure needs regular audit and this data should be used to guide On-going training and education programmes</p> <p>8. The process for training and assessment of competence as it relates to trainee doctors undertaking LISA needs to be more robust</p> <p>9. The resuscitation effort demonstrated that despite adequate and up to date training, relevant factors can be missed in the midst of a stressful situation</p>
<p>502879 -</p>	<p>The geography of the ward and the</p>	<p>1. Registered Nurses responsible</p>

Observation /Monitoring	<p>number of staff available means that an individual member of staff is not designated to observe the telemetry at all times. It is unclear from the Standard Operating Procedure (SOP) who is expected to observe and respond to alarms in a systematic way. Registered Nurses responsible for observing patients with telemetry monitoring do not receive specialised training and assessment of competence in cardiac competencies so they can safely assess ECG monitoring. There was some anxiety about the management of the cardiac arrest. There was lack of knowledge of the medicine management policy for the administration of Amiodarone.</p>	<p>for observing patients with telemetry monitoring should have specialised training and assessment of competence</p> <p>2. There should be a review and update of the Standard Operating Procedure for the management of telemetry and clarity provided about expectations of nursing staff with regards to observing and monitoring the alarms and the process for escalation/intervention where required</p> <p>3. There should be education for practitioners who predominantly work in the cardiac catheter labs as to LTHT medicines management policy for the administration of Amiodarone at ward level</p> <p>4. Enhanced resuscitation training to Immediate Life Support level is recommended for senior band 5/6 cardiology nurses</p> <p>5. There should be a review of the current staffing establishment on ward L19</p>
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6. Lessons Learned

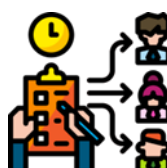
Identification of good practice and areas for improvement in care following a patient's deaths are an integral element of the mortality process within LTHT; this is inclusive of potentially avoidable deaths and learning identified following an investigation, as well as learning outlined following SJR.

Table 6: Trends in Relation to Good Practice



Communication & Collaboration

Good multi-disciplinary team approach was a frequent theme highlighted, as was good communication and engagement with families and patients, particularly near the end of life.



Clinical Management

Themes of good practice in clinical management were identified including early recognition, prompt advice from other specialties, assessments, and senior review.



Early Recognition and End of Life Care

Multiple specialties highlight good practice in regards to end of life care including early recognition of a dying patient, involvement of the palliative care team, exploring patients' wishes and providing good bereavement support.

Table 7: Trends in relation to areas for improvement



Timely Care and Handover

Prolonged waits in the Emergency department contributing to delays in receiving medications and senior review was highlighted as an area for improvement.



Documentation

Ensuring good practices in regards to documentation and ensuring documentation is timely and accurate was an improvement theme identified.

7. 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. There are currently no open Mortality Outlier Alerts.

8. Mortality Work Programme

In Q3 2022/23, the Mortality Improvement Group continued to invite specialties on a rotational basis to present a summary of their learning from deaths processes, and discuss the resulting learning and actions. The new SJR storage system was piloted in select specialties and further improvements will be made in Q4 2022/23 after feedback from clinicians.

In Q4 2022/23 The Coding team and Quality Governance Analyst would continue to work with specialties to monitor and review mortality indicators and coding data as required.

9. Publication Under Freedom of Information Act

Public domain:

- This paper has been made available under the Freedom of Information Act 2000

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