The Leeds Teaching Hospitals NHS Trust

Q1 2023/24 Quarterly Report on Learning from Deaths
Mortality Improvement Group
17 October 2023

Presented for:	Information and assurance
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Previous Committees:	Quality Assurance Committee – October 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	Moving Towards
Financial Risk				
External Risk				

Key points	
1. This is the quarter one 2023/24 report on Learning from Deaths. The report is in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
2. There was one death in quarter one 2023/24 that has been categorised as potentially avoidable and subject to formal incident investigations.	Information

1. Summary

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.

The latest Summary Hospital-level Mortality Indicator (SHMI) published in August 2023 for April 2022 - March 2023 is 1.1268 (decrease from 1.304 in July 2023). The Hospital Standardised Mortality Ratios (HSMR) for June 2022 – May 2023 is 112.5 (increase from 111.8). Both indices remain above the expected range and will continue to be monitored by the Mortality Improvement Group.

There was one potentially avoidable death identified in Quarter 1 2023/24. Further detail is included within section five.

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 August 2023 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12 month rolling period April 2022 to March 2023 for the Leeds Teaching Hospitals NHS Trust (LTHT) is 1.1268 (down from 1.304 in July 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.

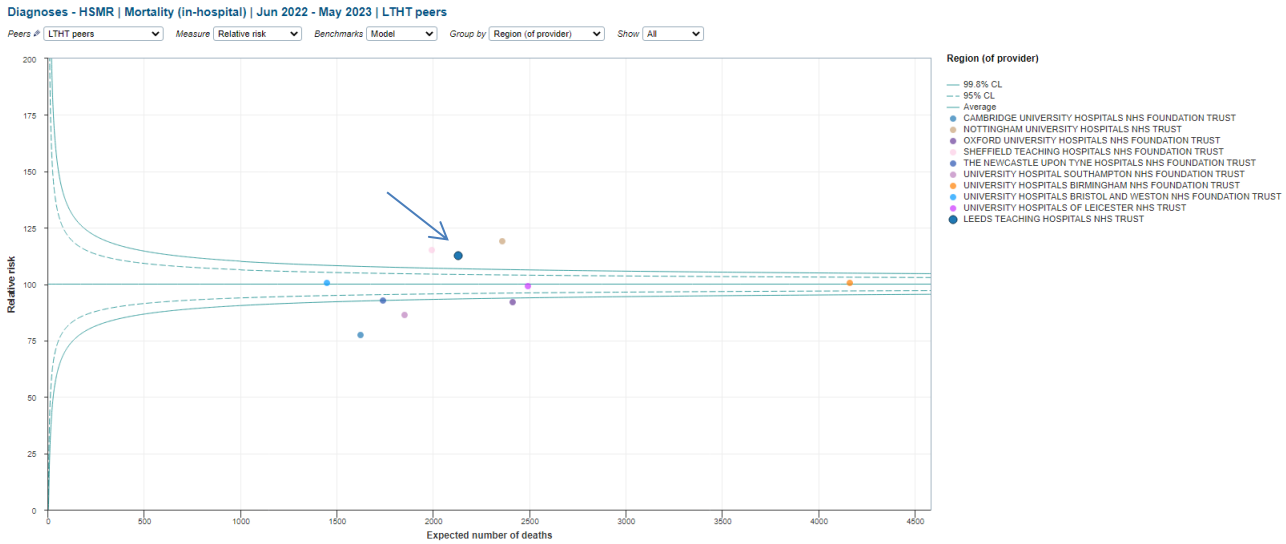
Table 1: National Mortality Indicators

	Figure (Aug-23 Publication)	Banding	Trend
SHMI	1.1268 (Apr-22 to Mar-23)	'Higher than expected'	↓
HSMR (basket of 56 diagnoses)	112.5 (Jun 22 to May-23)	'Higher than expected'	↑

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 continues to monitor the Trust's Mortality Indicators and will continue to undertake coding reviews alongside this process to ensure its quality 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 (Jun-22 to May-23)



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 17 August 2023.

CSU	Number of Deaths Eligible for Screening Q1 2023/24	Number Screened Q1 2023/24	Number Triggered Q1 2023/24
Specialty & Integrated Medicine	210	201	50
Cardio-Respiratory	143	127	39
Oncology	89	71	16
Abdominal Medicine and Surgery	95	92	36
Centre for Neurosciences	76	58	28
Trauma and Related Services	37	31	25
Urgent Care	33	29	5
Head and Neck	1	1	1
Chapel Allerton Hospital	0	0	0
Women's	0	0	0

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

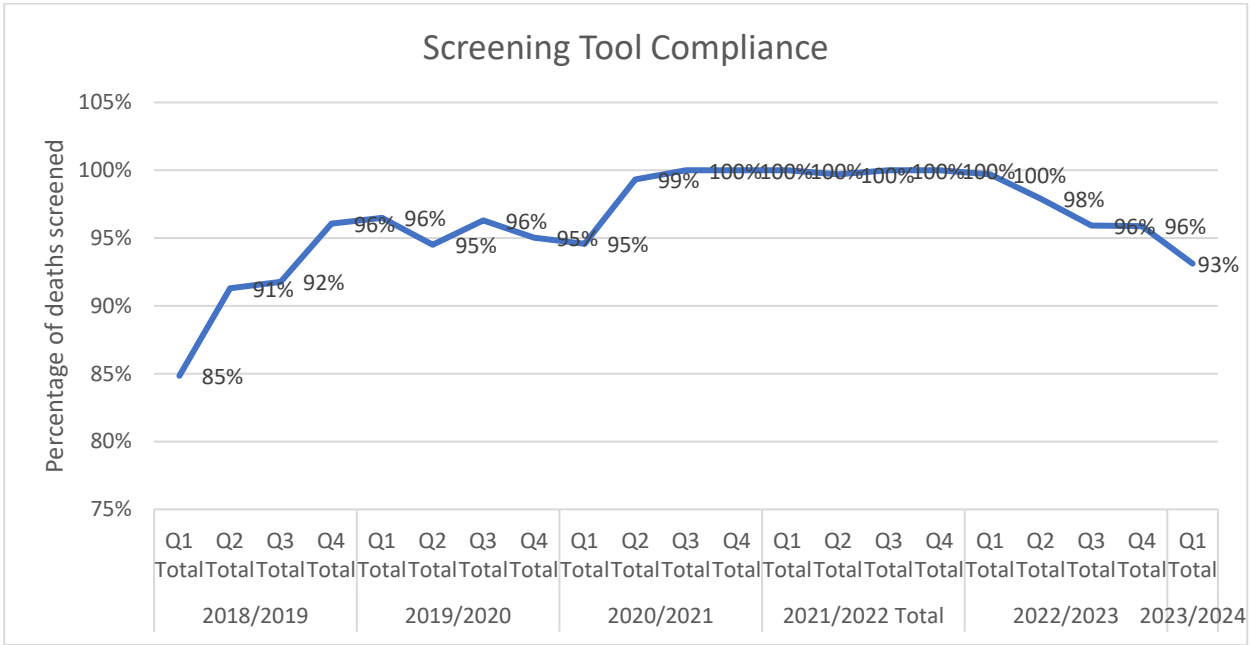


Figure 3.0: Percentage of Reviews Triggered from Screening process

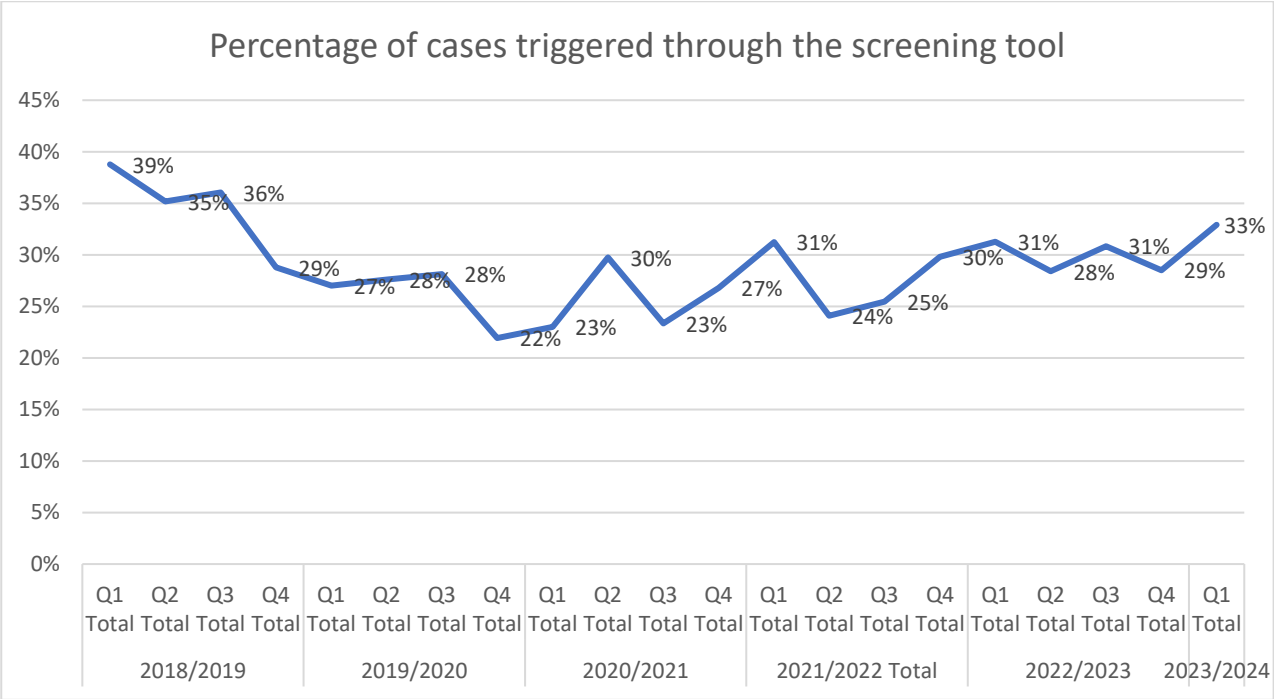
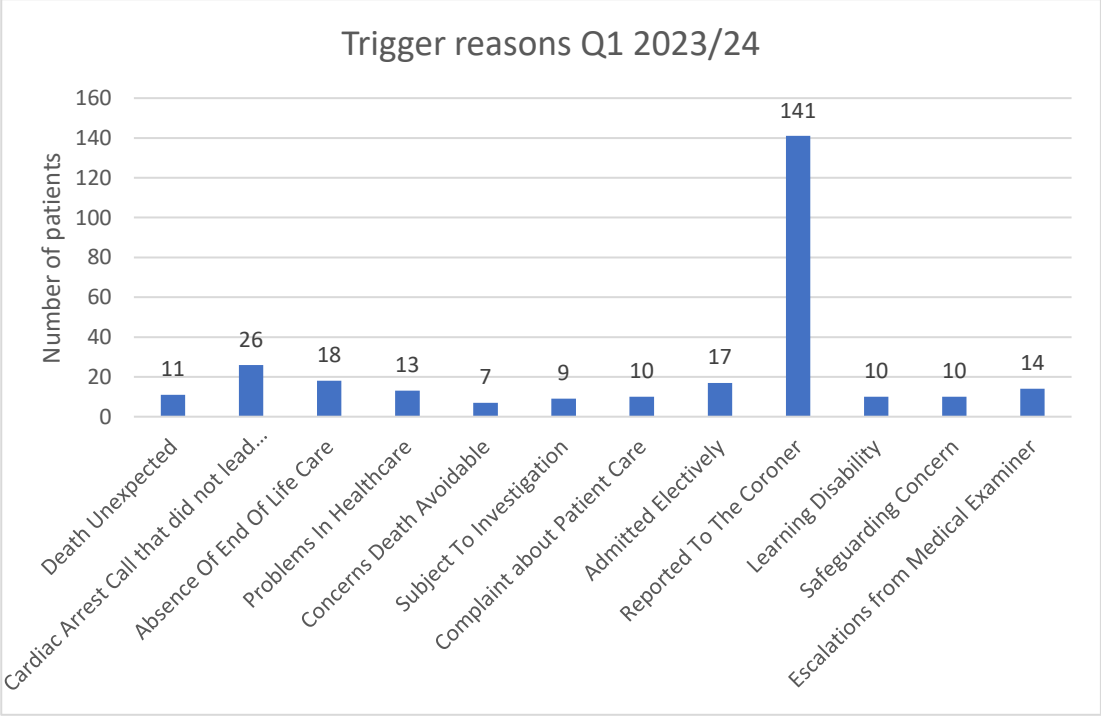


Figure 4.0: Trigger reasons summary Quarter 1 2023-24



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 191 mortality reviews (141 of which were Structured Judgement Reviews (SJR)) that were completed during Q1 2023/24. 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.

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. After implementation of improvements following a pilot launch in selected Specialties in Q3 2022/2023, full Trustwide launch took place in Quarter 1 2023/2024. Uptake of the online system will be monitored Quarterly.

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 level of investigation required.

This report includes all information obtained from Datix in Quarter 1 2023-2024 from 01/04/2023 up to and including 30/06/2023.

In the period: three deaths were reported and of these all three have been identified as possibly resulting from problems in healthcare and therefore were potentially avoidable. All these cases are subject to a formal review process. All three of the investigations are still on-going at the time of writing this report. Where investigations have concluded from previous reports, the outcome and learning are included below in Table 2. All three of the deaths for Q1 were reported to the Coroner.

In March 2023 a change was made to the reporting guidance for incidents where patients have died with Covid-19 identified on the death certificate. This was in response to national guidance on the reporting of these incidents. The previous process where an Associate Medical Director was tasked with reviewing all deaths from Covid-19 to determine "avoidability" has been removed. A local RCA review is still expected to take place in-line with LTHT incident management processes.

Table 2 - Potentially avoidable deaths as identified via the incident escalation function - Quarterly trend

Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24
4	4	6	4	10	6	6	1

Table 3 - Details of potentially avoidable deaths identified via the incident escalation function - Quarter 1 2023/24

Quarter 1 2023/24			
ID	**Level of Investigation**	**Category**	**Additional Information**
540588 (2023/10210)	Patient Safety Learning Review	Delay or failure to diagnose (cerebral bleed)	Investigation has not yet concluded

Lessons Learned from Completed Investigations - Quarter 1 2023/24

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 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 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 4 - Details of completed investigations into potentially avoidable deaths - Quarter 1 2023/24

Incident	Key findings	Lessons Learned
PSII 2022/25572- Delay or failure in treatment or procedure	Patient attended Emergency Department (ED) at St James's Hospital via ambulance with a history of general deterioration. Initial observations and timely triage took place. There were subsequent delays to further assessment and medications being given. The patient was discovered in the department with no signs of life 3 hours after observations were recorded and approximately 30 minutes after last seen by a member of staff.	1. Assessment and observations in the Emergency Department, including the measurement of NEWS and assessment of patient confusion 2. Ensure the presence of manual observation equipment as back-up for when the standard

	The nursing team at the time were organised in such a way that a number of key tasks were either missed or delayed. There was also a lack of regular detailed observations to monitor TK's general welfare. It was recognised that on the day of the incident the Emergency Department at St. James's Hospital was under extreme pressure from high patient activity in the department and difficulty in moving patients out who required admitting to an inpatient bed. Since the incident occurred it was recognised that the Trust has implemented its latest plan for managing levels of high activity. This included the introduction of an escalation process through identifying exceptional surge areas (ESA) to help relieve congestion and maintain patient safety in the Emergency Department during periods of sustained pressure and demand.	equipment is not providing data 3. Organisation of nursing team tasks utilising a named nurse model rather than a task-orientated system. 4. Organise nursing teams on each shift to maintain continuity of care as much as possible 5. Changes to organisation of bed spaces in ED treatment areas to maintain knowledge of patient's location through the department.
PSII 2023/2253 - Delay or failure in treatment for infection (sepsis)	Child born with gastroschisis. Post-surgery, on-going intestinal dysmotility and unable to achieve full feeds and required on-going parenteral nutrition via a PICC line placed via right leg into IVC. A fever of 39.6C, Tachycardia of 206 is recorded and reviewed by Surgical staff. Liaison between the Medical and Surgical teams took place through the day and antibiotics considered due to an indwelling central line. Blood results and chest x-ray reviewed and the possibility of line sepsis was discussed. This was not immediately acted upon. Much later in the day blood cultures were taken and first line antibiotics for sepsis were then prescribed and administered. A few hours later the baby collapsed and was unable to be resuscitated. The blood cultures sent were reported later in the morning as G-ve bacillus isolated in less than 24hrs.	1. The Sepsis Screening Tool needs to be available and consistently applied across all professional groups – either on PPM+ or as a paper document. 2. Nursing and parental concerns are an important part of clinical assessment, and it is important to consider any significant episodes that have occurred before medical review that may have now resolved. 3. There is a need for clarity for the surgical ward nursing staff with regards contacting senior surgical colleagues out of hours. 4. Break down hierarchical barriers – nursing staff need to be empowered to contact senior decision makers when concerned about a patient. 5. An initial diagnosis needs to be continually re-

		evaluated and where necessary challenged, to ensure that confirmation bias is avoided. 6. There is a need for clarity of the LIONS service amongst medical staff, particularly the surgical specialties. 7. Lines of responsibility are important to clarify along with routes of escalation for the LIONS team, when there are differences in opinion regarding clinical management of a patient. 8. Decision making in regards to whether the infected line should be removed was not clear. Development of specific paediatric guidance based on best practice would assist staff in these circumstances.
PSII 2022-20495 - Lack of, delayed availability of beds	A sixteen year old patient with known complex needs and was transitioning to adult services attended the Emergency Department with a presumed aspiration pneumonia. There patient waited over 24 hours for a bed to be available. The patient became increasingly distressed and the family requested that they took the patient home. Following discussion with a medical consultant it was agreed that the patient could go home. The patient was brought by ambulance back to the Emergency Department the following morning in cardiac arrest. Resuscitation was commenced but was not successful and the patient died in the department. There was a lack of clear guidance on the placement of patients aged 16 and 17 with significant on-going health needs who require acute admission to hospital. Lack of Involvement of the Learning Disabilities and Autism Team.	1. Development of a guideline on the placement of patients aged 16 and over with complex needs. 2. Improved referral systems between the Emergency Department and Learning Disabilities and Autism teams. 3. Improve speed of delivery of initial antibiotic doses in Emergency Department.

	Prolonged stay in the Emergency Department (>26 hours). Delay in administration of initial dose of antibiotics.	

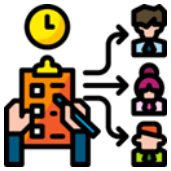
6. Lessons Learned

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 continue to 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 to families.

Table 7: Trends in relation to areas for improvement

Quality of documentation

Several specialties highlighted issues related to documentation particularly copy pasting information possibly contributing to confirmation bias and delays in documenting clinical encounters and use of retrospective notes.

Impact of industrial action

Several specialties noted a reduced capacity to discuss cases in their governance meetings due to the impact of the ongoing industrial action.

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

A new format for specialty mortality presentations in the Mortality Improvement Group has been developed. In Quarter 1, three specialties presented in the Mortality Improvement Group.

In April, a presentation was delivered exploring mortality in patients presenting to the Trust having suffered a stroke. The mortality trend from Dr Foster shows an increasing crude mortality rate and relative risk for this diagnosis group since July 2022. When correlating Dr Foster data with data from the Sentinel Stroke National Audit Program (SSNAP) several areas were identified for further exploration, in particular 1) access for direct admissions to stroke unit 2) mortality in stroke outliers and 3) rate of anticoagulation in patients presenting with stroke and atrial fibrillation. MIG agreed these topics should be further explored within the specialty and requested a follow up be presented in the Mortality Improvement Group in August 2023. The outcome of this will be presented within the quarter 2 report.

In June, the specialty presentations covered deaths in respiratory medicine and elderly medicine as well as Trust wide pneumonia mortality.

Respiratory medicines presentation did not identify any areas of concern and provided assurance that mortality is in line with other similar trusts in England. Trust wide, pneumonia admissions are triaged based on the CURB 65 score with those with highest scores admitted to respiratory medicine. LTHT had a higher portion of pneumonia admissions admitted to elderly medicine which may reflect an older cohort and different admission criteria for the specialty compared to other trusts. Arising actions included improving documentation of lobar pneumonia diagnosis which would allow more accurate coding. This will be managed within the Speciality Mortality and Morbidity meeting.

Elderly medicine in LTHT sees an older and frailer cohort compared to peers in the region based on data from Dr Foster. The specialty also had a higher proportion of activity also coded with COVID 19 compared to major trauma centre and regional peer average and excess mortality was noted particularly in patients with COVID 19 as a secondary diagnosis – this however may reflect variation in the way patients with COVID19 have been streamed in different trusts. It was also highlighted that patients admitted to virtual wards are not included in the analysis and increased use of virtual wards for fitter patients with lower risk of mortality may skew the figures due to reduced number of admissions.

A lower rate of specialist palliative care coding was noted in all presentations compared to peers, however, assurance was provided that high quality palliation is being delivered

within the specialties due to training and awareness within the Trust, therefore there is no plan to recommend increased involvement of the specialist palliative care team when high quality palliation can be achieved within the parent specialities.

In Q2 2023/24 specialty presentations will cover deaths in Emergency Department as well as an update on the work carried out by the stroke team following the initial presentation in April 2023. The Coding team and Quality Governance Analyst continue to work with specialties to monitor and review mortality indicators and coding data as required. Uptake of the SJR online system will be monitored following the full Trust wide launch in Quarter 1 2023.

9. Financial Implications

There are no financial implications with this report.

10. Risk

The Quality Assurance Committee provides assurance oversight of the Trust's most significant risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

11. Communication and Involvement

The Mortality Improvement Group works in collaboration with the Clinical Service Units Mortality Leads, Corporate Services and Medical Examiner. There is senior medical management oversight of learning from deaths activities by the Associate Medical Director (Risk Management). This work is monitored by the Quality and Safety Assurance Group**.**

12. Equality Analysis

The Mortality Review Policy – Learning from Deaths supports a comprehensive approach to ensuring safe and effective patient care has taken place through a robust mortality review process; particularly in relation to patients with a Learning Disability or Autism

13. Publication Under Freedom of Information Act

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

14. Recommendation

The Quality Assurance Committee are asked to note the Quarter 1 2023/24 report on Learning from Deaths.

15. Supporting Information

No applicable.

Jenni Gronroos
Quality Governance Analyst (Mortality)
September 2023