The Leeds Teaching Hospitals NHS Trust

Q4 2022/23 Quarterly Report on Learning from Deaths
Trust Board
28 September 2023

Presented for:	Information and Assurance
Presented by:	John Adams, Medical Director (Risk and Governance)
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Previous Committees:	None

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		Choose an item.	Choose an item	Choose an item.
Operational Risk		Choose an item.	Choose an item	Choose an item.
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		Choose an item.	Choose an item	Choose an item.
External Risk		Choose an item.	Choose an item	Choose an item.

Key points	
1. This is the quarter four 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 four 2022/23 that have 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 May 2023 for January 2022 - December 2022 for the Leeds Teaching Hospitals NHS Trust (LTHT) is 1.134 (up from 1.1312 in April 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). The Hospital Standardised Mortality Ratio (HSMR) for March 2022 – February 2023 for LTHT is 113.7 (a decrease from 114.3) which is above the expected range. All these indices will continue to be monitored by the Mortality Improvement Group.

There were six potentially avoidable deaths identified in Quarter 4 2022/23.

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 May 2023 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12 month rolling period January 2022 to December 2022 for the Leeds Teaching Hospitals NHS Trust (LTHT) is 1.134 (up from 1.1312 in April 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.

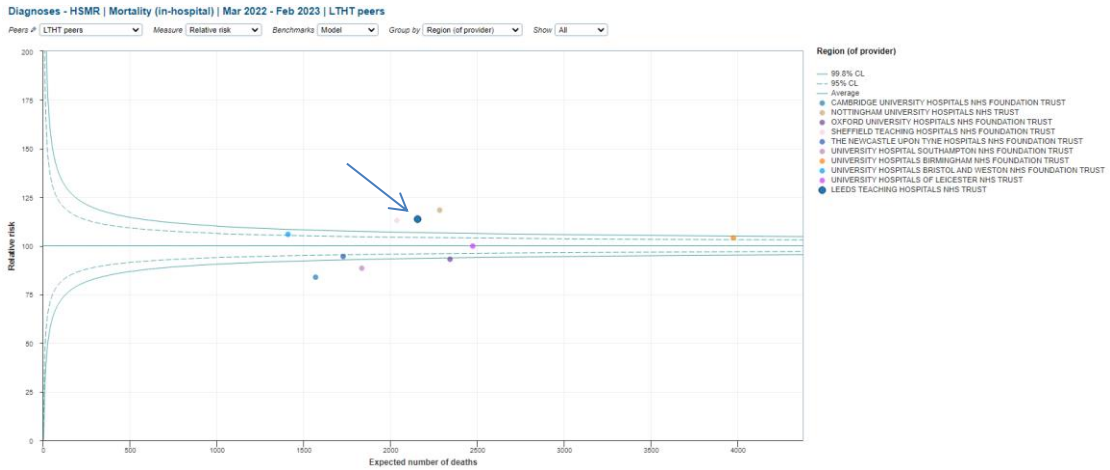
Table 1: National Mortality Indicators

	Figure (May-23 Publication)	Banding	Trend
SHMI	1.134 (Jan-22 to Dec-22)	'Higher than expected'	↑
HSMR	113.7 (Mar 22 to Feb-23)	'Higher than expected'	↓

(basket of 56 diagnoses)	

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 updated and approved in January 2022 to outline a revised process for monitoring Mortality Reviews (namely Structured Judgment Reviews) to better enable themes of learning to be identified. 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 7 June 2023.

CSU	Number of Deaths Eligible for Screening Q4 2022/23	Number Screened Q4 2022/23	Number Triggered Q4 2022/23
Specialty & Integrated Medicine	269	262	51
Cardio-Respiratory	140	134	20
Oncology	89	83	22
Abdominal Medicine and Surgery	78	76	33
Centre for Neurosciences	73	63	27
Trauma and Related Services	37	29	22
Urgent Care	36	34	10
Head and Neck	2	1	1
Chapel Allerton Hospital	0	0	0
Women's	0	0	0

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

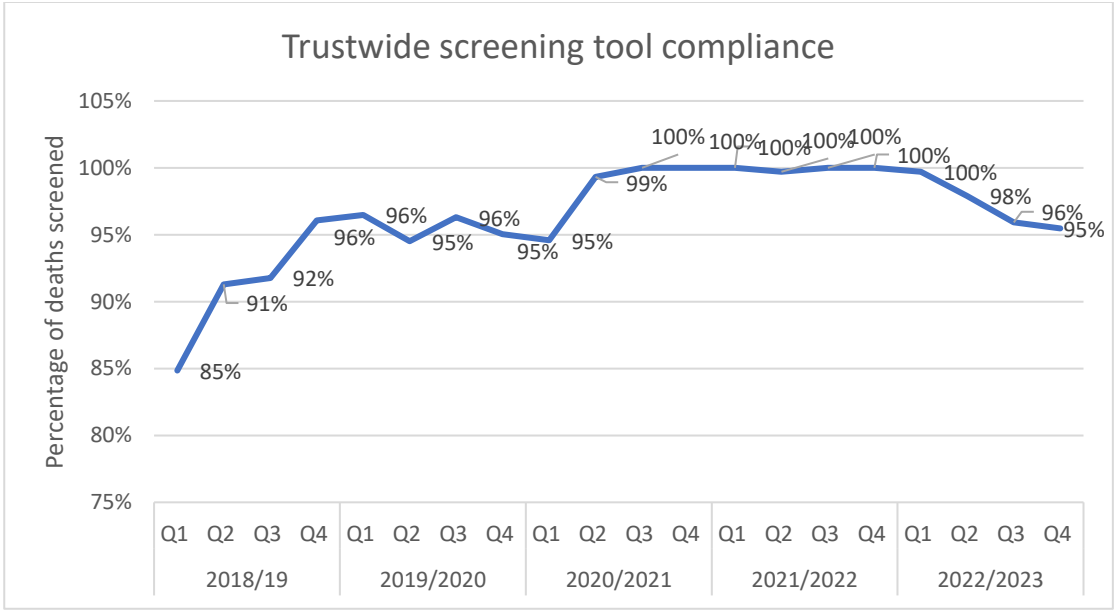
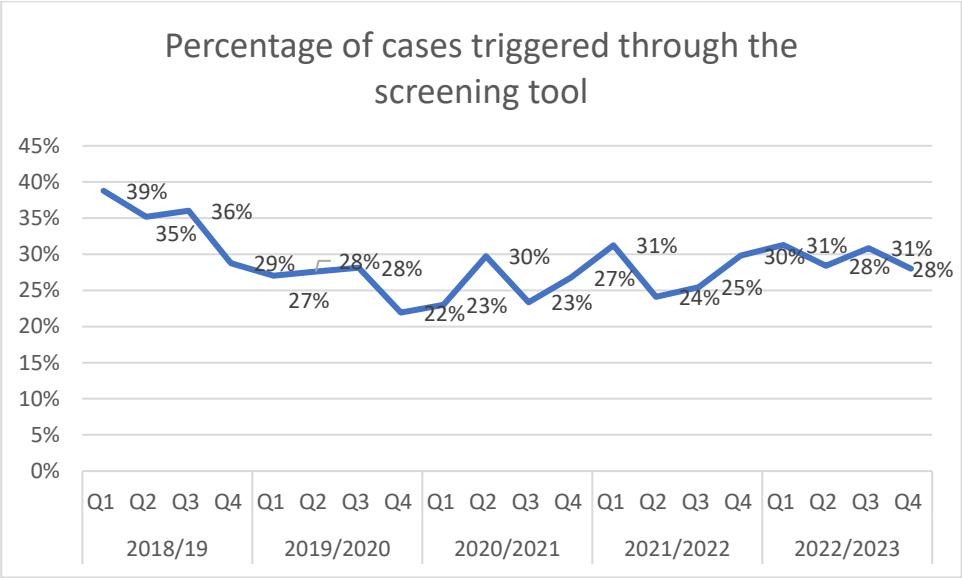


Figure 3.0: Percentage of Reviews Triggered from Screening process



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 149 mortality reviews (109 of which were Structured Judgement Reviews (SJR)) that were completed during Q4 2022/23. 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.

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. Following feedback from pilot launch in selected Specialties in Quarter 3, further improvements are being made on the site with full Trustwide launch expected to take place in Quarter 1 2023/2024.

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 4 2022-2023 from 01/01/2023 up to and including 31/03/2023.

In the reporting 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. All six 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. Four of the deaths for Q4 were reported to the Coronial Office.

Table 3 - Potentially avoidable deaths as identified via the incident escalation function - Quarter 4 2022/23

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

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

Quarter 3 2022/23			
ID	**Level of Investigation**	**Category**	**Additional Information**
517399	PSII 2023/6585	Unexpected death following discharge	Investigation has not yet concluded
534238	PSII 2023/5848	HCAI RCA (Serratia)	Investigation has not yet concluded
522540	PSII 2023/1044	Unwitnessed Fall resulting in death	Investigation has not yet concluded
531083	PSII 2023/4253	Failure to identify deteriorating patient	Investigation has not yet concluded
531354	PSII 2023/4252	Difficult airway management	Investigation has not yet concluded
533392	PSII 2023/5850	Supply of Medication	Investigation has not yet concluded

5.1 Lessons Learned from Completed Investigations - Quarter 4 2022/23

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 3 - Details of completed investigations into potentially avoidable deaths - Quarter 4 2022/23

Incident	Key findings	Lessons Learned
503574 - Witnessed fall on level ground (resulting in death)	• Patient had a witnessed fall whilst rising from a wheelchair when he was awaiting transport home after a prolonged stay in the ED at LGI. A mandatory falls assessment had not been completed upon arrival at the ED and the prolonged stay may have increased the risk of falls in an already frail patient. • Patient was re-seated in a wheelchair because the high attendance and congestion in the ED had triggered a "fit to sit" exercise to free up trolleys. There are no published standards for the "fit to sit" exercise and no record of the criteria used. • Communication between clinical staff in the ED and ward regarding transfer	• Wheelchairs carry a risk of falls that is greater than alternative fixed seating so should be avoided unless the mobility is essential. • When the patient was unexpectedly found out of bed on one knee this should have immediately been regarded as a fall, triggering completion of a falls proforma.

	was good. An Enhanced Care Risk Assessment was not performed on admission to the ward although all other assessments were completed. Investigation has revealed that the implemented intentional rounding represented an appropriate level of care based upon the available assessment even though earlier 1:1 care had been implemented post fall in the ED before transfer. • It has not been possible to pinpoint exactly when the patient sustained a fractured neck of femur. Records following the fall in ED indicate that the patient was able to stand and mobilise on his leg and there was no reference to a shortened or rotated leg which would be indications of a fractured neck of femur. • Neither the suspicion of a fractured neck of femur, nor the escalation to medical staff is documented in the notes, nor was it raised with a more senior doctor during the ward round that followed. Equally, the doctor who assessed the patient did not document he was aware of the suspicion of a fracture, or any reasons for not acting on this. • Documentation of ReSPECT discussions was not fully completed. However, this is unlikely to have influenced the ultimate clinical outcome because of later discussions that occurred.	
505248 - Adminstration (of Medication)	• Patient was treated on an ortho-geriatric ward with a vascular condition when commenced on a high-risk medication (Intravenous heparin). • The guidance on the heparin chart was not followed. There were missed opportunities to check and act on APTT ratios. • The laboratory procedure for telephoning critical values to wards was not followed. The results were communicated to the treating ward, however the name and job title of the person receiving the results was not documented.	• Documentation must be checked if it has been dictated and written by someone else, mis-hearing or missing vital information is likely to occur in a busy ward environment. • The Trust does not have a guideline for the management of patients on intravenous(IV) unfractionated heparin. The Trust should develop guidance, including best practice on management, monitoring, dosing and

	• There was no clinical documentation that the heparin had been stopped for an hour or a reason for why this was done. • There was a discrepancy between what the consultant thought they had said on the ward round and what was annotated in the comprehensive notes, which resulted in the omission of checking the APTT ratio before switching to low weight molecular heparin. • There was a 90-minute delay in administering protamine following the Haematology registrar's guidance	switching to other anticoagulant agents • On eMeds when one anticoagulant is prescribed for a patient already on an anticoagulant a warning flashes up alerting the prescriber to the risk of bleeding. This does not flag for IV heparin, which is prescribed as 'see chart.' • As the team were remote from the ward having complex infusions such as heparin on eMeds may help with review. Education and training on the management of IV heparin should be reviewed and updated with learning from this case.

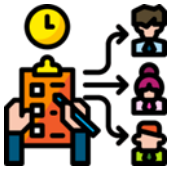
6. Lessons Learned

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. Multidisciplinary team working was also highlighted as strength by specialties in several CSUs.

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

Timely Care and Handover

Prolonged waits in the Emergency department contributing to delays in initial and speciality assessment, senior review and care delivery was highlighted as an area for improvement.

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

In Q4 2022/23, further improvements are being made in to the SJR storage system after feedback from clinicians. A new format for specialty mortality presentations in the Mortality Improvement Group is being developed.

In Q1 2023/24 A new format for specialty mortality presentations in the Mortality Improvement Group will be trialled with Stroke Medicine. The Coding team and Quality Governance Analyst would continue to work with specialties to monitor and review mortality indicators and coding data as required.

The SJR storage system is anticipated to be launched Trust wide in Q1 2023/24.

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 is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

14. Recommendation

The Trust Board are asked to note the quarter 4 2023/24 report on Learning from Deaths.

15. Supporting Information

Not applicable.

Jenni Gronroos
Quality Governance Analyst (Mortality)
June 2023