The Leeds Teaching Hospitals NHS Trust

Q2 2023/24 Learning from Deaths Report
Trust Board
28 March 2024

Presented for:	Information and assurance
Presented by:	Magnus Harrison, Chief Medical Officer
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Previous Committees:	Mortality Improvement Group 12 December 2023 Quality Assurance Committee 22 February 2024

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 two 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 were four deaths in quarter two 2023/24 that have been categorised as potentially avoidable and subject to formal patient safety 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 November 2023 for July 2022 - June 2023 is 1.1243 (increase from 1.1226 in October 2023). The Hospital Standardised Mortality Ratios (HSMR) for September 2022 – August 2023 is 109.4 (decrease from 110.7). Both indices remain above the expected range and will continue to be monitored by the Mortality Improvement Group.

There were four potentially avoidable deaths identified in Quarter 2 2023/24.

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 November 2023 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period July 2022 to June 2023 for the Leeds Teaching Hospitals NHS Trust (LTHT) is 1.1243 is banded "higher than expected" as is an increase from the SHMI published in October 1.1226 which was banded "as 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.

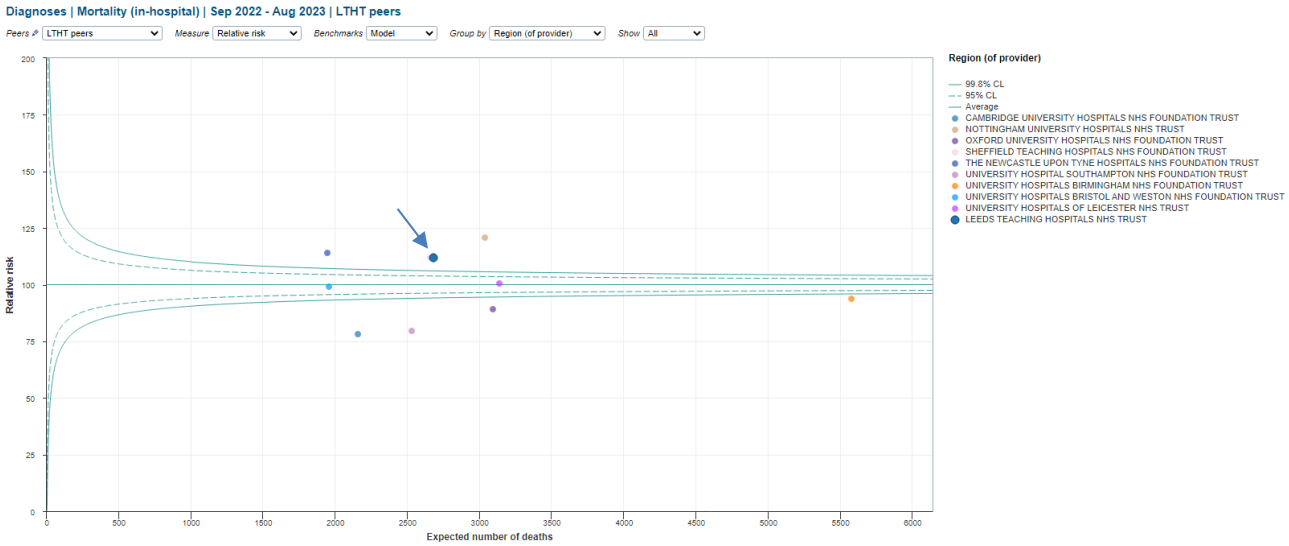
Table 1: National Mortality Indicators

	Figure (Nov-23 Publication)	Banding	Trend
SHMI	1.1243 (Jul-22 to Jun-23)	'Higher than expected'	↑
HSMR (basket of 56 diagnoses)	109.4 (Sep 22 to Aug-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 diagnosis group, 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 accuracy and the accuracy of our Mortality statistics. Structured Judgement Reviews (SJR) will also be requested and monitored through the new SJR storage system provide assurance that the care we are providing is safe and effective.

Figure 1.0 LTHT Dr Foster SMR vs. Peers (Sep-22 to Aug-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 15 November 2023.

CSU	Number of Deaths Eligible for Screening Q2 2023/24	Number Screened Q2 2023/24	Number Triggered Q2 2023/24
Specialty & Integrated Medicine	199	185	38
Cardio-Respiratory	110	101	39
Oncology	80	72	19
Abdominal Medicine and Surgery	57	54	21
Centre for Neurosciences	66	53	18
Trauma and Related Services	29	22	15
Urgent Care	22	20	6
Head and Neck	2	1	1
Chapel Allerton Hospital	1	1	1
Women's	1	0	0

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

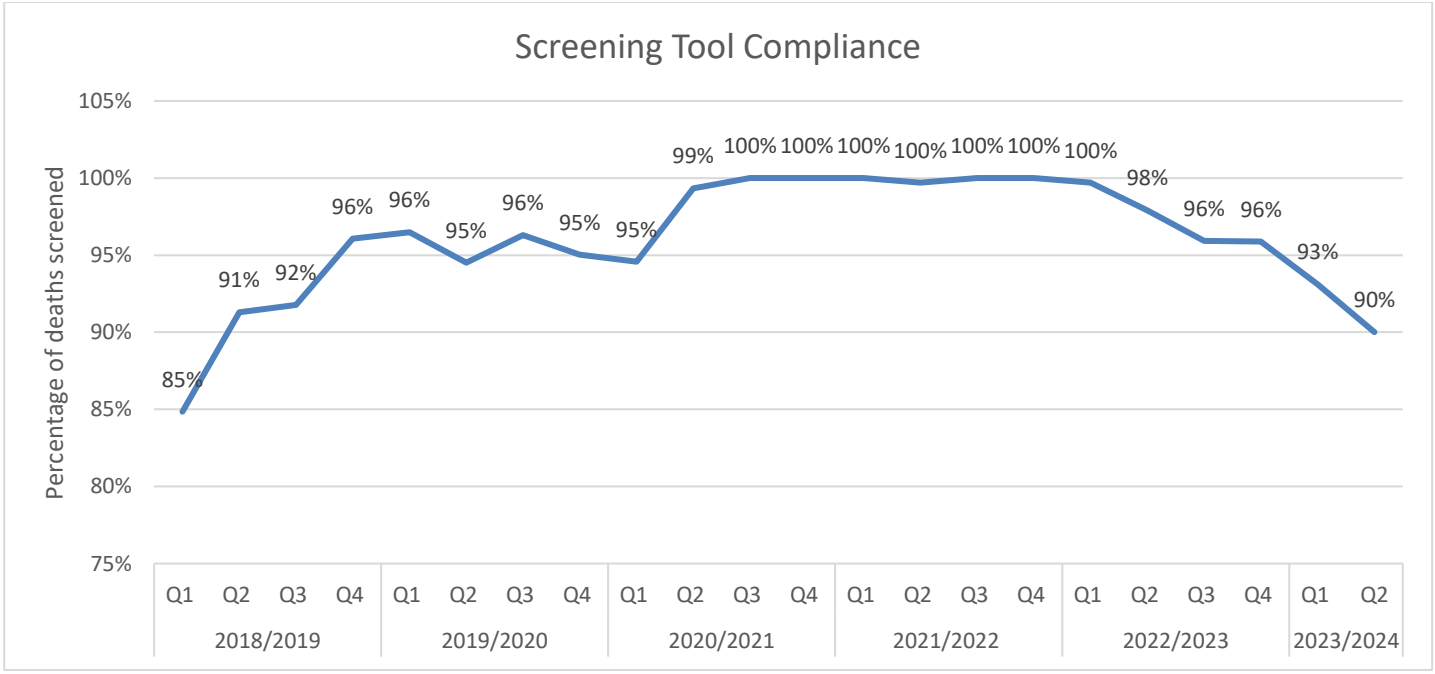
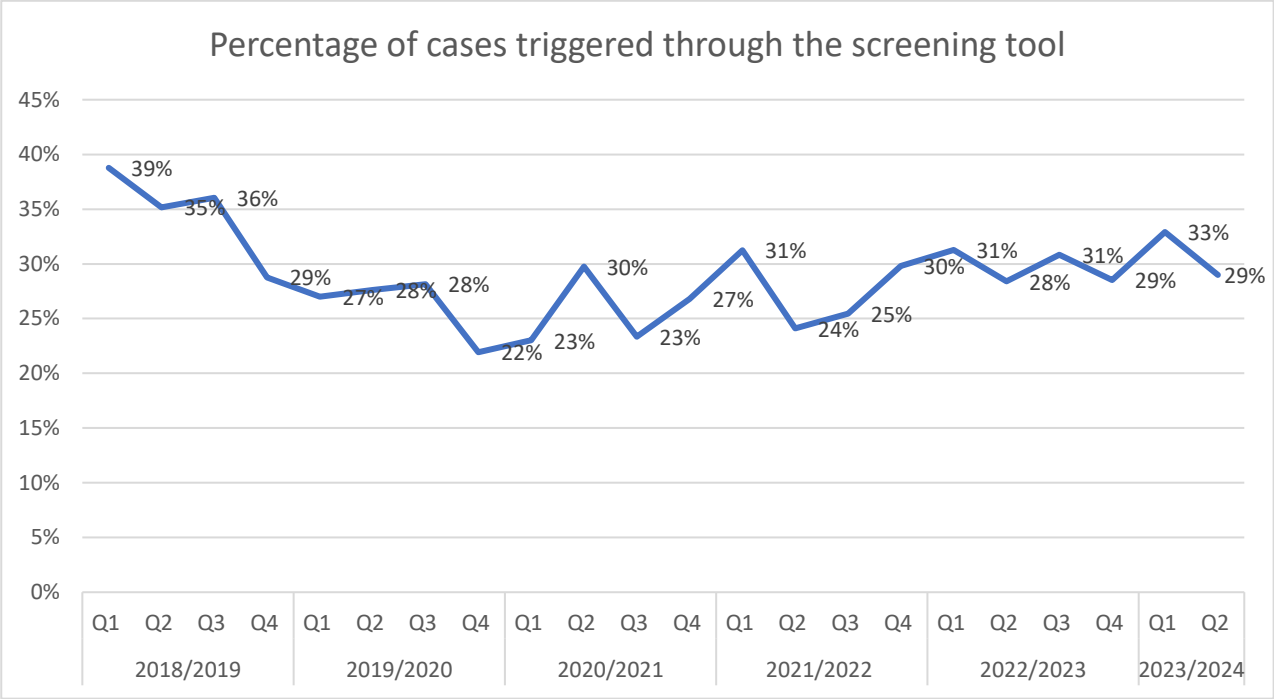


Figure 3.0: Percentage of Reviews Triggered from Screening process



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 111 mortality reviews (70 of which were Structured Judgement Reviews (SJR)) that were completed during Q2 2023/24. The reduced number of reviews completed reflects a lower rate of returns received from specialties as well as several specialties discussing reduced number of cases due to staff absence. 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. A full Trust wide launch of an online SJR storage system took place in Quarter 1 2023/24. The uptake of the site on specialty level continues to be monitored and issues identified resolved as they arise.

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 2 2023-2024 from 01/07/2023 up to and including 30/09/2023.

In the period: Ten deaths were reported and of these four have been identified as possibly resulting from problems in healthcare and therefore were potentially avoidable. All these cases are subject to formal review process. Three of the investigations are still on-going and one has been completed at the time of writing this report. Where investigations have concluded from previous reports, the outcome and learning are included below in Table 4. All four of the deaths for Q2 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 3 - Potentially avoidable deaths as identified via the incident escalation function - Quarterly trend

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

Table 4 - Details of potentially avoidable deaths identified via the incident escalation function - Quarter 2 2023/24

This table has been redacted from submission to Public Board to ensure anonymity to patients and their families. Full detail has been received and considered at the Quality Assurance Committee.

Lessons Learned from Completed Investigations - Quarter 2 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 5 - Details of completed investigations into potentially avoidable deaths - Quarter 2 2023/24

This table has been redacted from submission to Public Board to ensure anonymity to patients and their families. Full detail has been received and considered at the Quality Assurance Committee.

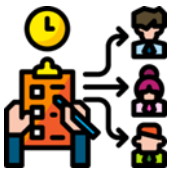
6. Lessons Learned

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 practices relating 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 and compassionate care to families and patients.

Table 7: Trends in relation to areas for improvement

Outlying patients

Several specialties highlighted issues relating to patients residing in outlying areas and the importance of transferring the patient to the parent specialty's bed space as soon as clinically appropriate.

Language barrier

Several specialties highlighted challenges with using Language line and difficulty in obtaining face to face interpreter to facilitate complex conversations with patients and families as an area for improvement.

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 Program

A new format for specialty mortality presentations in the Mortality Improvement Group has been developed. In Quarter 2, two specialties presented in the Mortality Improvement Group.

In August, a follow up presentation was delivered exploring mortality in patients presenting to the Trust with a stroke. An earlier analysis on the mortality trend from Dr Foster showed an increasing crude mortality rate and relative risk for this diagnosis group since July 2022.

An audit undertaken by the specialty demonstrated an increased crude mortality rate in stroke outliers and in stroke patients under other specialties. When patients who were on End of Life pathway at the time of ward allocation were excluded, the mortality rate for outlying patients under the stroke team reduced while the mortality rate for patients under other teams remained high. To address this issue the stroke has commenced weekly consultant led ward rounds on the St James' site. The team is also exploring options to cohort stroke patients receiving end of life care in one a specific ward in LGI to support high quality EOL care delivery.

A peer comparison of the Sentinel Stroke National Audit Programme (SSNAP) October - December 2022 data was carried out comparing the casemix between LTHT and 4 other similar trusts in the region (Sheffield Teaching Hospitals NHS Foundation Trust, University Hospitals Of North Midlands NHS Trust, The Newcastle Upon Tyne Hospitals NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust.)

Of the 5 trusts, LTHT had the second highest proportion of patients having a history Atrial Fibrillation (AF) before stroke. Rates of anticoagulation for patient with AF were second lowest amongst peers. The specialty is working with Integrated Care Board (ICB) to improve AF detection and anticoagulation rates in the community.

In August the emergency medicine team presented a review of deaths in Emergency Department after a previous analysis had shown an unusual peak in deaths in December 2023. All 52 deaths were reviewed and in majority of cases patients presented with an out of hospital cardiac arrest or with end stage disease such as advanced malignancy. A full Structured Judgement Review was completed for 16 patients who were long waiters, had learning disability or concerns were raised in the mortality screening tool. Although the number of deaths was higher than usual, there was no evidence to suggest quality of care was compromised as all 52 deaths were unavoidable.

The mortality screening tool available on PPM+ was updated in September 2023 to include a question about autism and following this the informatics team have worked to create a new mortality screening tool dashboard to better visualise the data.

In Q3 2023/24 specialty presentations will cover sepsis mortality and well as a review mortality in cardiology. 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 trustwide 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 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 Quality Assurance Committee are asked to note the Quarter 2 2023/24 report on Learning from Deaths.

15. Supporting Information

Not applicable.

Jenni Gronroos
Quality Governance Analyst (Mortality)
December 2023