

Mortality Review – Learning from deaths Q3 2024/25

Public Board

31 July 2025

Presented for:	Information and assurance
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Previous Committees:	Quality Assurance Committee, Mortality Improvement Group

2025/26 Commitments	Category	✓
Support our patients to get home a day sooner	Care	
Be in the top 25% trusts for patient experience and efficiency in outpatient	Quality	
Support each other to act with kindness and compassion	Team	
Recognise and act upon moments that matter to our patients	Compassion	✓
Support our staff to spend every pound wisely	Finance	
Make best use of our estate, equipment and digital assets	Resources	✓
Reduce our carbon footprint by creating greener patient pathways	Sustainability	

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. 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.	Assurance
2. The latest Summary Hospital-level Mortality Indicator (SHMI) published in March 2025 for November 2023 – October 2024 is 1.1211 (decrease from 1.122 in February 2025). The Hospital Standardised Mortality Ratios (HSMR) for January 2024 – December 2024 is 108.6 (increase from 108.5). Both indices will continue to be monitored by the Mortality Improvement Group.	Information
3. In Q3 2024/25 seven deaths were escalated through the 'potential patient safety incident' reporting processes.	Information
4. 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 potential patient safety incident reporting processes and learning identified following an investigation, as well as learning outlined following SJR	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 March 2025 for November 2023 – October 2024 is 1.1211 (decrease from 1.122 in February 2025). The Hospital Standardised Mortality Ratios (HSMR) for January 2024 – December 2024 is 108.6 (increase from 108.5). Both indices will continue to be monitored by the Mortality Improvement Group.

In Q3 2024/25 seven deaths were escalated through the 'potential patient safety incident' reporting processes

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 2025 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period November 2023 to October 2024 for the Leeds Teaching Hospitals NHS Trust (LTHT) was 1.1211, banded "as expected" and was a decrease from the SHMI published in February 2025 1.122, which was banded "as expected".

The SHMI continues to be 'above expected' for Leeds General Infirmary (LGI) while remaining "as expected" for St James' University Hospital (SJUH) site 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.

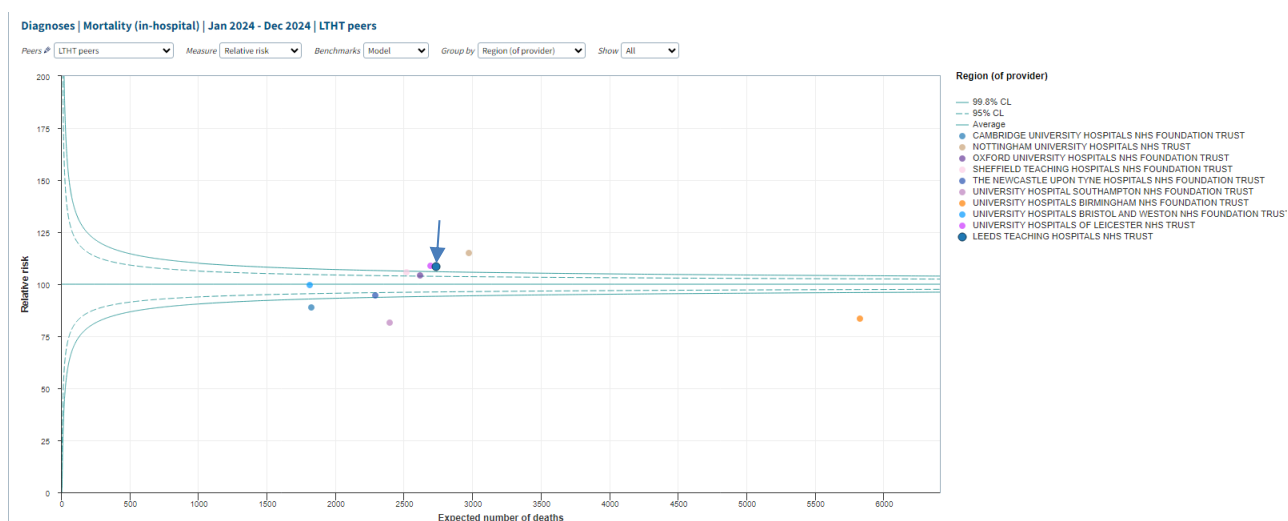
Table 1: National Mortality Indicators

	Figure (Mar-25 Publication)	Banding	Trend
SHMI	1.1211 (Nov 23 to Oct 24)	'As expected'	↓
HSMR+ (basket of 41 diagnoses)	108.5 (Jan 24 to Dec 24)	'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.

In November 2024, Telstra Health UK implemented several changes in its Dr Foster model, including updates to the diagnosis groups included in the HSMR cohort as well as changes to the factors contributing to the risk adjustment model. The Mortality Improvement Group continues to monitor the impact these changes have on the Trust's mortality metrics.

Figure 1.0 LTHT Dr Foster SMR vs. Peers (Jan 24 to Dec 24)



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 27 March 2025.

CSU			Number of Deaths Eligible for Screening	Number Screened	Number Triggered
			Q3 2024/25	Q3 2024/25	Q3 2024/25
Specialty Medicine	&	Integrated	247	239	37
Cardio-Respiratory			146	141	28
Oncology			92	88	18
Abdominal Surgery	Medicine	and	108	107	51
Centre for Neurosciences			80	72	22
Trauma and Related Services			46	43	26
Urgent Care			44	44	15
Head and Neck			1	1	1
Chapel Allerton Hospital			0	NA	NA
Women's			0	NA	NA

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

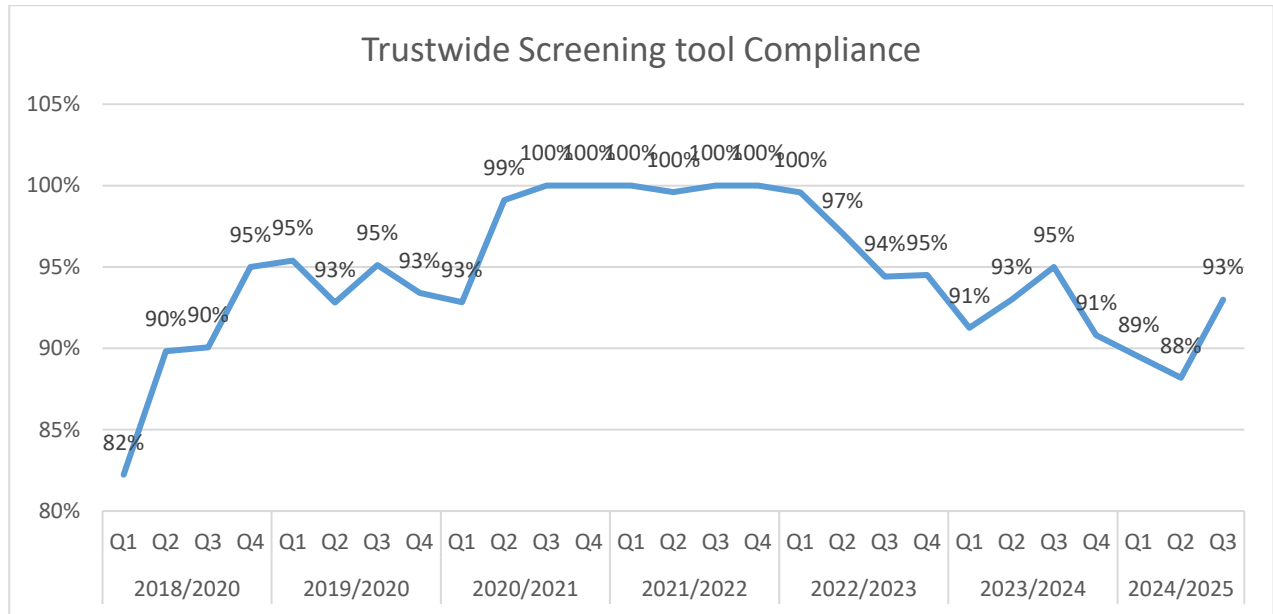


Figure 3.0: Percentage of Reviews Triggered from Screening process

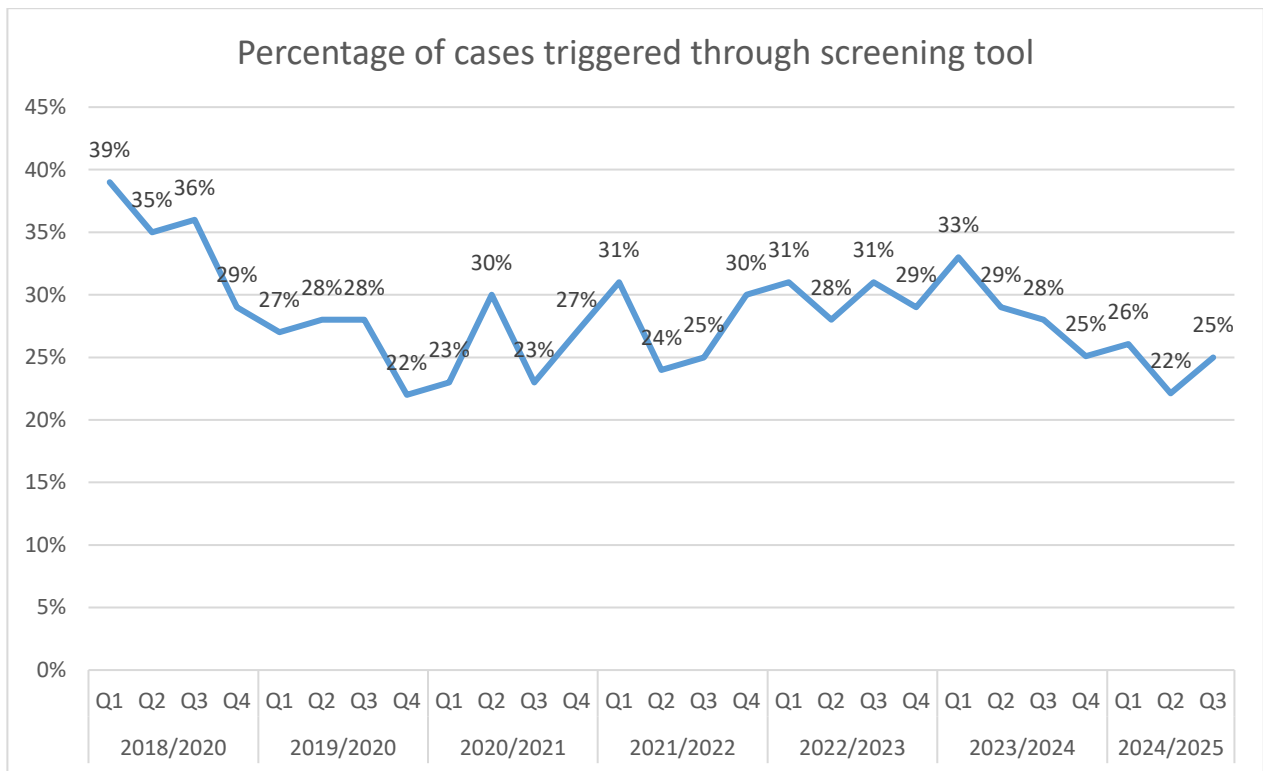
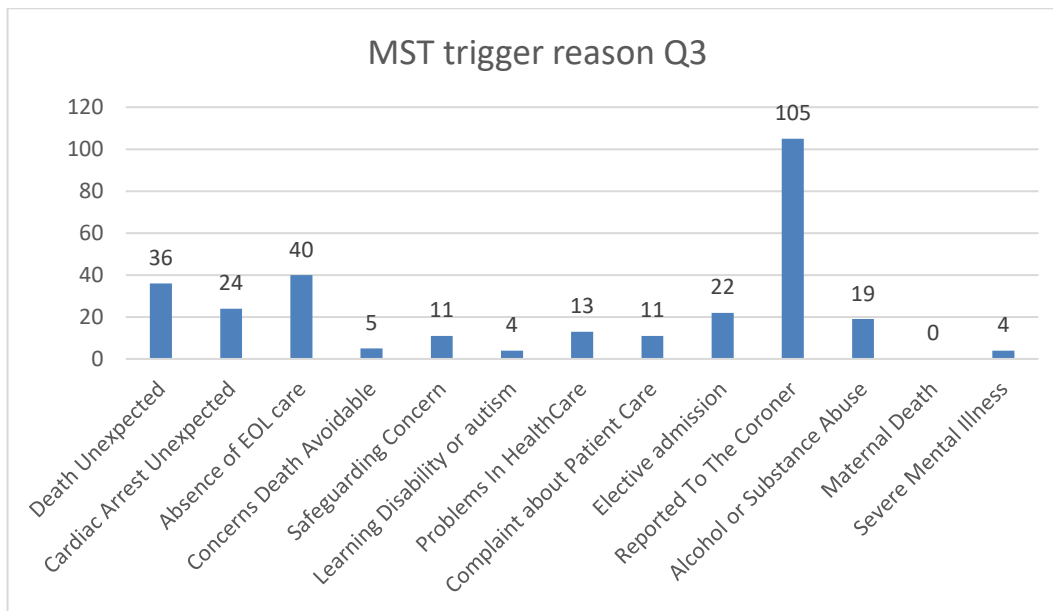


Figure 4.0: Mortality screening tool trigger reason



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 138 mortality reviews (122 of which were Structured Judgement Reviews (SJR)) that were completed during Q3 2024/25. In Q3, 157 SJRs were completed on the online system. The team received a completed return from 16 specialties. Incomplete returns were particularly received from Centre for Neurosciences CSU. No return was received from cancer centre CSU, Trauma and related services CSU and Children's CSU.

All patient deaths are subject to alternative review methodology in the Leeds Children's Hospital, 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.

5. Summary of Investigations and Learning following a patient death

The Trust is required to report quarterly on the number of deaths reviewed through the Patient Safety Incident Response Framework (PSIRF). 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 as to the type and level of review required. Incidents that are escalated are as defined within our Patient Safety Incident Response Plan 2024-26.

This report includes all information obtained from Datix in Quarter 3 2024-2025 from 01/10/2024 up to and including 31/12/2024.

During this period: Seven deaths were escalated. Table 3 below provides details of the incidents which were escalated, and the level of review required following discussion at the Weekly Quality Meeting. Six of the seven deaths escalated were referred to the coroner.

Where reviews have concluded from previous reports, the outcome and learning are included below in Table 5.

Table 3 - Deaths escalated - Quarterly trend

Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/23	Q1 2024/25	Q2 2024/25	Q3 2024/25
1	4	4	0	0	5	7

Table 4 - Details of deaths identified via the incident escalation function - Quarter 3 2024/25

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.

Findings and actions from Completed Reviews

Findings and actions from all Patient Safety Incident Investigations are discussed at various Quality meetings including the Trust Quality Governance Forum and Quality Assurance Committee.

Since July 2024 a Patient Safety Learning Hub has been developed. The meeting encourages representatives from all CSUs to attend to discuss how lessons learned from incidents, audits, safety alerts and other sources can be shared effectively across the Trust and in a manner where the learning can be retained.

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.

An overview of completed learning review outcomes following the death of a patient are summarised in the table below. The table includes details of key findings, lessons learned, identified improvements and actions to address the care and service delivery issues identified.

Learning reviews are conducted in line with the Trust's Investigations Procedure with the focus being on learning to avoid reoccurrence of incidents.

Table 5 - Details of completed reviews. – Quarter 3 2024/25

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

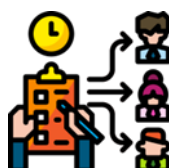
Identification of good practice and areas for improvement in care following a patient's deaths are an integral element of the mortality process within LTHT; this is inclusive of potential patient safety incident reporting processes and learning identified following an investigation, as well as learning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

6.1 Lessons highlighted by the CSUs

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.

**Clinical Management**

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

**ED wait times**

Few specialties highlighted issues in relation to long wait in ED including delays in assessment, treatment and transfer to a ward.

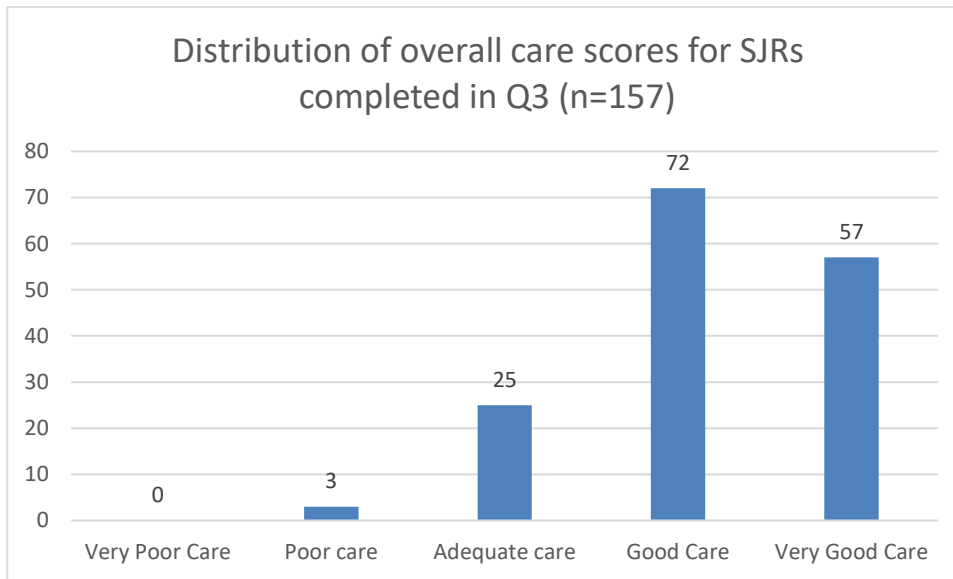
**Discussions related to interventions**

Several specialties highlighted cases where more in depth discussion of surgical and non-surgical procedures with patients and/or families could have been considered.

6.2 Themes from SJRs

In Q3 24/25, 157 SJRs were completed on the online SJR system. In three reviews the overall score given by the initial reviewer was 2 (poor care). Learning was identified in relation to anchoring bias leading to delayed diagnosis, long wait for inpatient bed in ED due to system pressure, and lack of specialist medical cover in LGI.

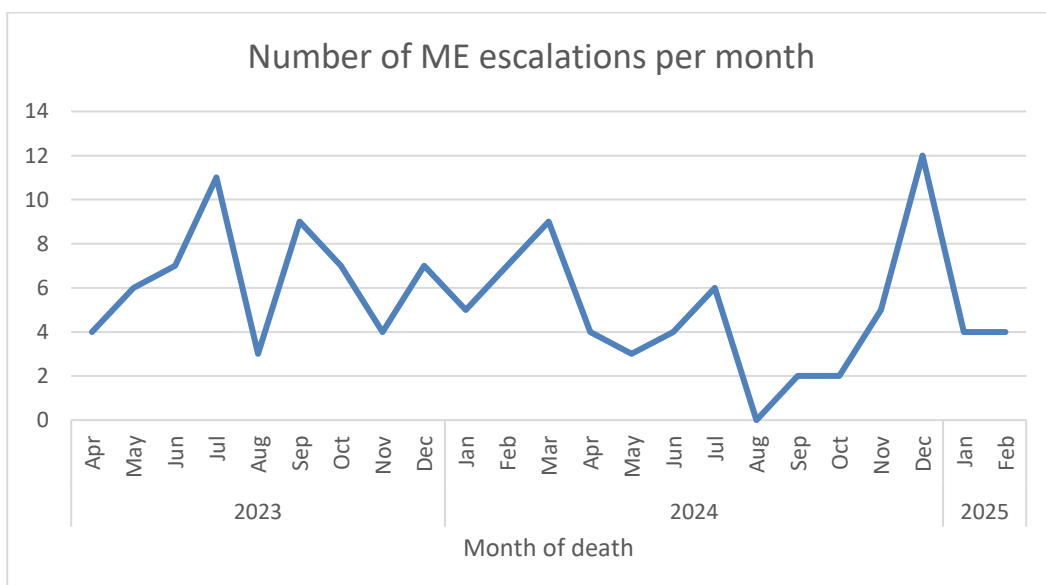
Figure 5 Distribution of Overall care scores for SJRs completed in Q3 24/25



6.3 Themes from escalations from the Medical Examiner service

In Quarter 3 2024/25 19 cases were escalated by the Medical Examiner service for review, two of which related to deaths in the community. There was a notable peak in escalations in December with 12 escalations. No common themes were identified.

Figure 6 Number of ME escalations per month



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

In Quarter 3, the mortality presentations covered mortality in patients admitted with Sepsis, AKI and Fractured Neck of Femur as well mortality in patients admitted under T&O team

Hip fractures constituted a large proportion of T&O admissions in LGI. Data from the National Hip Fracture Database showed the hospital's 30-day survival rate for hip fracture patients was below national average. The Crude 30-day mortality rate had increased from 5.3% in 2022 to 7.0% in 2023 and Adjusted 30-day mortality rate from 5.3% in 2022 to 7.3% in 2023. The time to theatre for these patients was longer, with the hospital ranking the ninth worst in the country. Historical data showed that improvements in time to theatre were associated with lower mortality rates. On Dr Foster data for patients admitted with hip fracture between July 2023 and June 2024, LTHT had a larger proportion of patients staying in hospital for more than 28 days compared to MTC average (25% vs 15%).

On Dr Foster data, sepsis mortality was within the expected range following the update in the risk adjustment model in November 2024. The number of sepsis admissions had notably declined since September 2023, which had also resulted in a decline in the expected number of deaths. This contributed to the widening of the gap between the number of observed and expected deaths resulting in an increasing relative risk.

The sepsis team presented a summary of an audit of 11 patients, who died in LTHT from May 2023 – July 2024, who had not been coded with sepsis as a primary diagnosis on admission. These patients had been selected for review due to being primarily diagnosed with conditions with potential overlap with sepsis. 8/11 patient had been coded as infection on admission, particularly necrotizing fasciitis (2), UTI (2) and lobar pneumonia (2).

On review of the records, all of the patients either had suspicion of sepsis, were coded as sepsis on discharge, or were at high risk of sepsis based upon observations and evidence of organ failure (AKI >2 or Lactate >2).

Learning was identified around improving the recognition and documentation of suspected sepsis diagnosis, performing blood and other cultures, utilisation of fluid balance charts and the timing of fluid boluses, antibiotic administration and senior review. The sepsis team planned to continue working with the ED team, offering directed teaching as well as working on quality improvement projects. Additionally, the coding team had reviewed a sample of the audited cases and short FCEs were noted as a contributory factor to the lower rate of sepsis coding.

The rolling 12-month relative risk on Dr Foster for patients admitted with acute kidney injury showed an increasing relative risk since June 2023 with higher-than-expected mortality in the last three rolling 12-month periods up to August 2024. Rolling 12-month trend for number of admissions showed an increase in the number of admissions following a post-pandemic dip. The rolling 12-month trend showed a widening gap between the observed vs expected deaths, which had resulted in the increasing relative risk. When benchmarked against peers,

the relative risk for this patient cohort was within the expected range in LTHT. However, the RR for LTHT still remained above peer average along with two other trusts.

50% of admissions and 63% of deaths were in patients with history of renal failure, accounting for 12.5 of the 17.1 excess deaths in the trust. There had been an increasing number of admissions in most age groups with the exception of the 85+ cohort. Half of the patients who died following AKI admission had initially been admitted and died under elderly medicine.

In regard to length of stay, an increased number of deaths had primarily been seen in admissions with LOS of 5+ days, with 29 of the 67 deaths occurring within the first week of admission. Only 58% (39/67) of AKI admissions still had AKI as the primary diagnosis at death, with ten patients having a diagnosis of sepsis, pneumonia or UTI as primary diagnosis on death.

In Q4 2024/25 specialty presentations will cover mortality in patients with learning disability and autism. The Coding team and Quality Governance Analyst continue to work with specialties to monitor and review mortality indicators and coding data as required.

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 Mortality Improvement Group are asked to note the Quarter 3 2024/25 report on Learning from Deaths.

15. Supporting Information

Not applicable.

Jenni Gronroos
Quality Governance Analyst (Mortality)
April 2025