

Q3 2023/24 Quarterly Report on Learning from Deaths

Trust Board

30 May 2024

Presented for:	Information and assurance
Presented by:	Magnus Harrison, Chief Medical Officer
Author:	Jenni Gronroos, Quality Governance Analyst (Mortality) Eve Butterfield Incident and Learning Manager
Previous Committees:	Mortality Improvement Group 16 April 2024 Quality Assurance Committee 18 April 2024

Our Annual Commitments for 2024/25 are:	
Reduce wait for patients	
Reduce Healthcare Acquired Infections by 15%	
Reduce our carbon footprint through greener care	
Use our existing digital systems to their full potential	
Strengthen participation and growth in research and innovation	
Deliver the financial plan	
Be in the top 25% performing Trusts for staff retention	

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 three 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 three 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 March 2024 for November 2022 – October 2023 is 1.1193 (decrease from 1.1215 in February 2024). The Hospital Standardised Mortality Ratios (HSMR) for January 2023 – December 2023 is 108.5 (decrease from 111.4). 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 3 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 March 2024 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period November 2022 to October 2023 for the Leeds Teaching Hospitals NHS Trust (LTHT) was 1.1193 banded “higher than expected” and was an decrease from the SHMI published in February 2024 1.1215 which was banded “above expected”.

The SHMI continues to be ‘above expected’ for Leeds General Infirmary (LGI) while remaining “as expected” for St James’ University Hospital (SJJUH) 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.

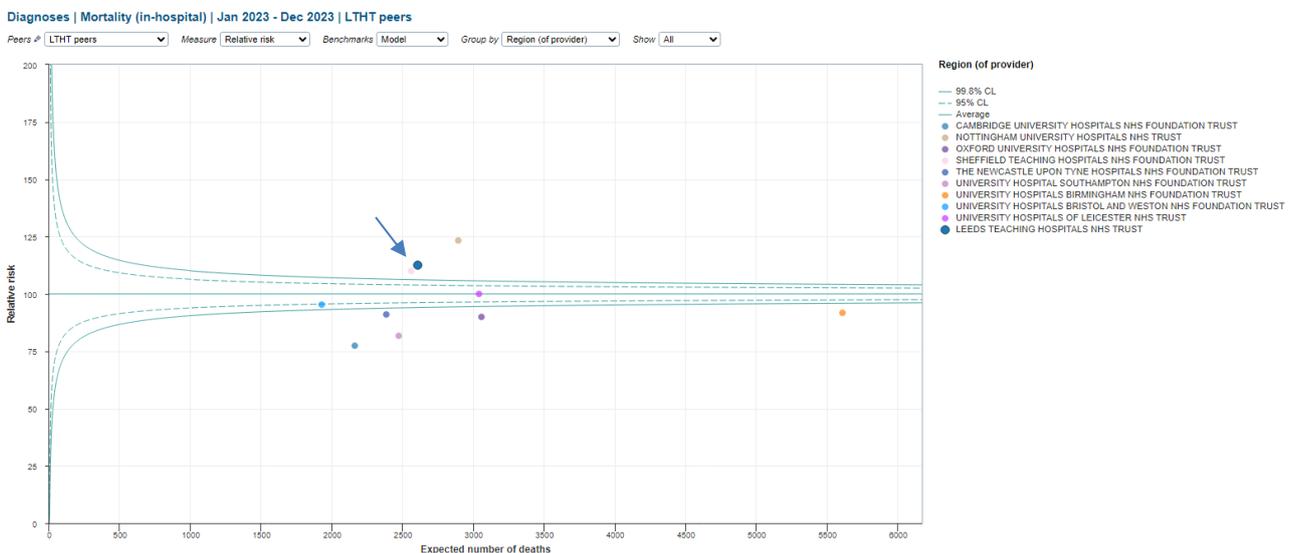
Table 1: National Mortality Indicators

	Figure (Mar-24 Publication)	Banding	Trend
SHMI	1.1193 (Nov 22 to Oct-23)	‘Higher than expected’	↓

HSMR (basket of 56 diagnoses)	108.5 (Jan 23 to Dec-23)	‘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 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 (Jan 23 to Dec 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 20 March 2024.

CSU	Number of Deaths Eligible for Screening	Number Screened	Number Triggered
	Q3 2023/24	Q3 2023/24	Q3 2023/24
Specialty & Integrated Medicine	237	229	47
Cardio-Respiratory	122	107	29
Oncology	93	86	18
Abdominal Medicine and Surgery	97	97	36
Centre for Neurosciences	79	68	21
Trauma and Related Services	64	51	29
Urgent Care	41	39	13
Head and Neck	2	2	1
Chapel Allerton Hospital	1	1	1
Women's	NA	NA	NA

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

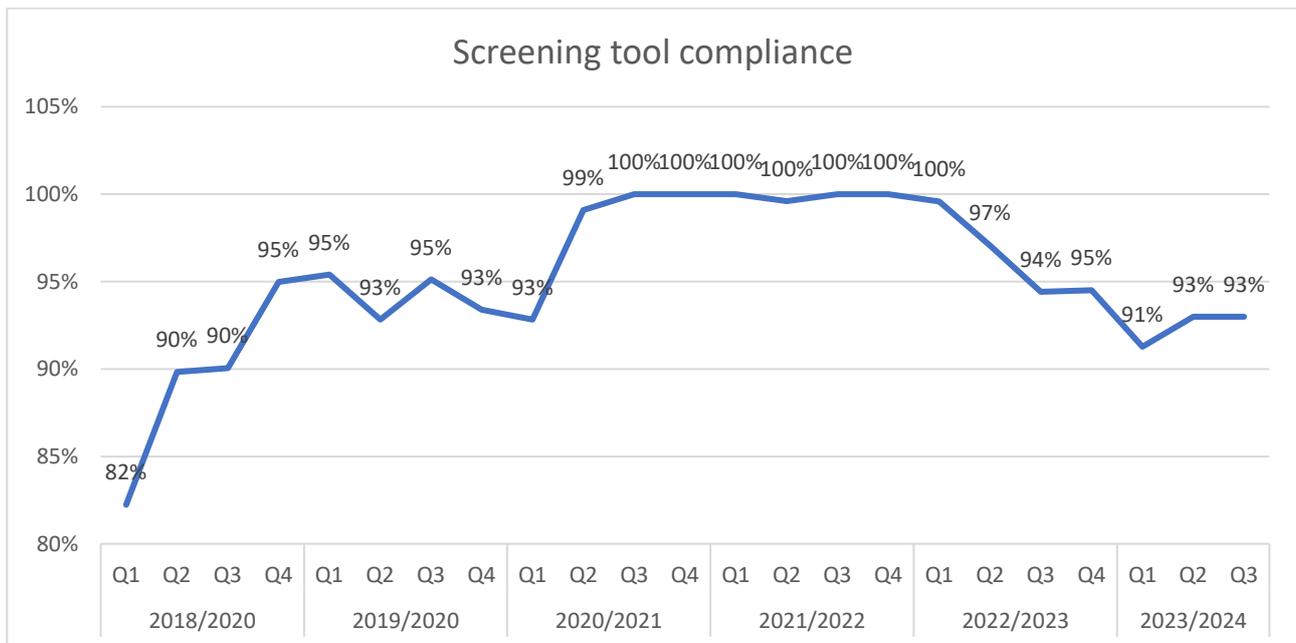


Figure 3.0: Percentage of Reviews Triggered from Screening process

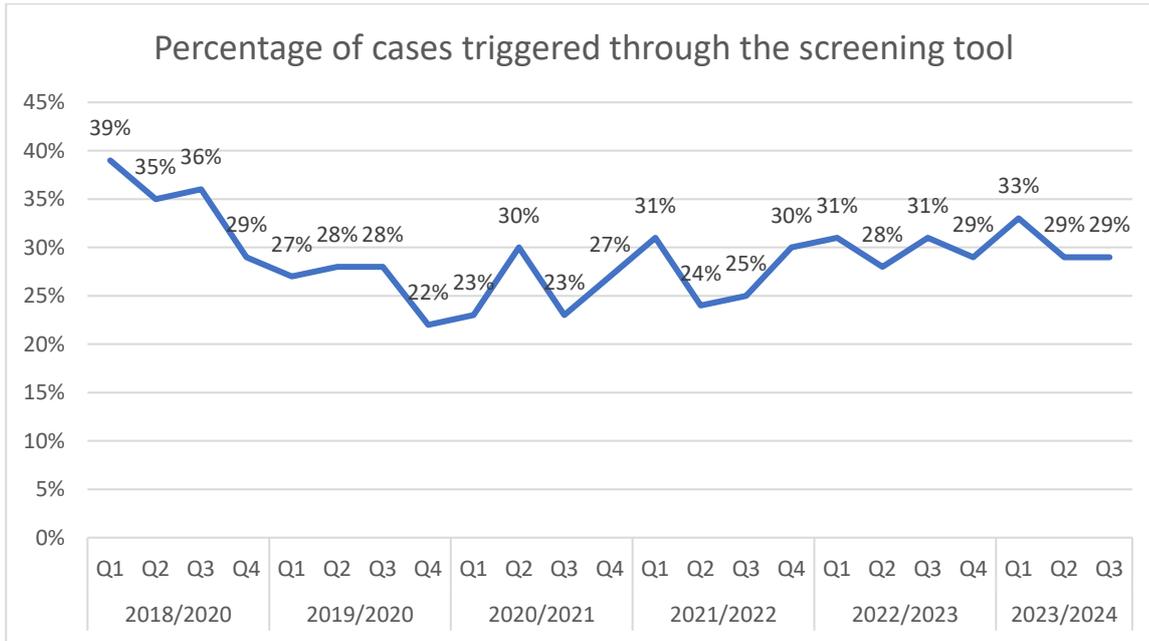
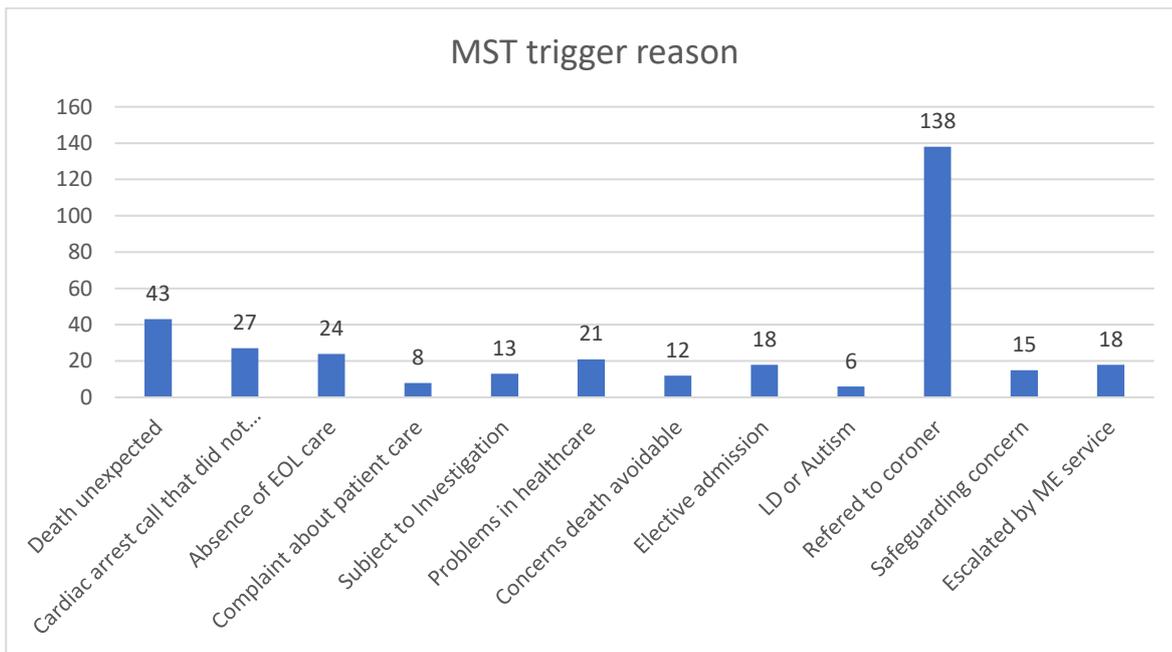


Figure 4.0: Mortality screening tool trigger reason



4.2 Completion of Clinical Reviews

The Quality Governance Team was notified of 209 mortality reviews (162 of which were Structured Judgement Reviews (SJR)) that were completed during Q3 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.

The team received a completed return from 25 specialties. Incomplete returns were particularly received from Centre for Neurosciences CSU, Oncology CSU and Trauma and Related Services CSU.

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 review required. Patients who potentially died because of an in-patient fall are included in these numbers and each fall will undergo a Patient Safety Learning Review in line with the falls review process.

This report includes all information obtained from Datix in Quarter 3 2023-2024 from 01/10/2023 up to and including 31/12/2023.

In the period: Seven 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 a formal review process. Three of the reviews are still on-going and one has been completed at the time of writing this report. Where reviews have concluded from this and previous reports, the outcome and learning are included below in Table 2. All four of the deaths for Q3 were reported to the coroner.

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	Q3 2023/24
10	6	6	1	4	4

Table 4 - Details of potentially avoidable deaths identified via the incident escalation function - Quarter 3 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 Reviews - Quarter 3 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 completed incident reviews and the learning from these are summarised in the table below. The table shows details of key findings, lessons learned and identified improvements and actions to address the care and service delivery issues identified.

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 recurrence of the incident and not to determine the avoidability of the consequences.

Table 5 - Details of completed investigations into potentially avoidable deaths - Quarter 3 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 sites and the importance of transferring the patient to the parent specialty's bed space as soon as clinically appropriate.



Documentation

Several specialties highlighted issues relating to insufficient documentation of conversations between specialties as well as accessing ED notes.

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 3, the mortality presentations covered sepsis, myocardial infarction and deaths in patients admitted under cardiology.

In October an analysis of trust-wide mortality in patients admitted with sepsis was discussed. A discrepancy was noted between different mortality metrics used to review sepsis mortality. The crude mortality rate on the SOS insight tool was within the expected range as was the rolling 12-month SHMI value. Dr Foster data showed a rolling 12-month relative risk above the expected range from May 2022 to April 2023 for "Septicaemia (except in labour)" diagnosis group. This was found to correlate with a period where there was a reduction in the number of monthly admissions where sepsis was coded as the primary diagnosis affecting particularly older cohorts. Furthermore, a number of admissions where the sepsis was coded as a secondary diagnosis was identified.

The monthly number of sepsis admissions as well as the relative risk for this diagnosis group has returned within the normal range.

In December mortality for patients with a specialty of discharge of cardiology was reviewed. The rolling 12-month relative risk trend showed an increasing relative risk which had become statistically significantly elevated since May 2023. Cardiology in LTHT remained an outlier when the relative risk was benchmarked against 5 similar trusts.

While the age distribution of emergency admissions was similar to peers, LTHT had a lower proportion of admissions in the higher Charlson Comorbidity score groups. Excess deaths were particularly seen in the 45-64 age group as well as in patients with Charlson comorbidity score of 0. On review of internal trust data, in January – October 2023 27 of the 64 deaths in this age group occurred in critical care areas.

All four diagnosis groups with statistically significantly excess mortality were in diagnosis not typically managed by cardiology such as pneumonia.

In contrast to many trusts in England, critical care is not an admitting specialty in LTHT. While in most other trusts deaths of cardiology patients in critical care would be reported under critical care, in LTHT these patients were included in the cardiology mortality figures. These patients may be younger or less comorbid than patients who die on the ward resulting in an apparent increase in deaths in this younger, fitter cohort of patients.

Furthermore, as all patients in critical care need to belong to a ward-based specialty, some patients were nominally admitted under cardiology despite having primarily non cardiac diagnosis or receiving no cardiology input. Additionally, medical patients presenting to the LGI ED may be admitted under cardiology if they are not suitable for transfer to SJUH due to severity of their condition or due to being near end of life. Both of these groups of patients are more likely have a poor prognosis not accounted for by the model.

After exclusion of 6 diagnosis groups of patients with primarily non cardiology related admission diagnosis the relative risk returned within the expected range and did not show similar increasing trend as seen before.

The trust-wide mortality for Myocardial infarction diagnosis group had returned within the expected range. Earlier analysis had shown increased relative risk particularly in patients who had been admitted to SJUH site. This was thought to relate to these patients more likely being older, presenting with later complications of Myocardial Infarction such pulmonary oedema, or with concurrent acute medical problems. A coding review of 11 of these patients resulted in the primary diagnosis being changed in two cases. It was suggested that coders may have been influenced by the cause of death when primary diagnosis was not clearly documented in the medical notes and training material has been developed to address this. The mortality for this diagnosis group is well within the usual range for peers.

In Q4 2023/24 specialty presentations will cover perinatal mortality. 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 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 Mortality Improvement Group are asked to note the Quarter 3 2023/24 report on Learning from Deaths.

15. Supporting Information

Not applicable.

Jenni Gronroos
Quality Governance Analyst (Mortality)
March 2024