Harrogate and District NHS Foundation Trust

Board Meeting Held in Public
Wednesday 27th November 2024

Title:	Learning from Deaths Quarterly Report Q2: Jul-Sep 2024
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	Paper also submitted to Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

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Learning from Deaths Quarter 2 Report

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national level.

SHMI remains around the expected level and compares favourably with regional and national peer organisations.

19 cases have undergone a structured judgement review since the last report, 13 of which were from deaths in the Q2 period. Our new Datix SJR module is now live and enables better oversight and interrogation of SJR themes.

2.0 Introduction

Although mortality represents a very small percentage of all trust activity, it is important that it is monitored and examined appropriately. This report aims to triangulate mortality indices with other markers of quality of care, in particular that provided by structured judgemental reviews (SJRs) of medical notes.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 175 deaths were recorded in Q2, slightly up from 171 in the preceding Q1 and also compared to Q2 in 23/24 which had 168 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the 12 month rolling mortality has generally declined since 20210 (apart from the impact of the Covid pandemic). It should be remembered that the denominator for this data is the number of hospital episodes, so as we increase elective work (including endoscopies), the percentage of deaths would be expected to fall.

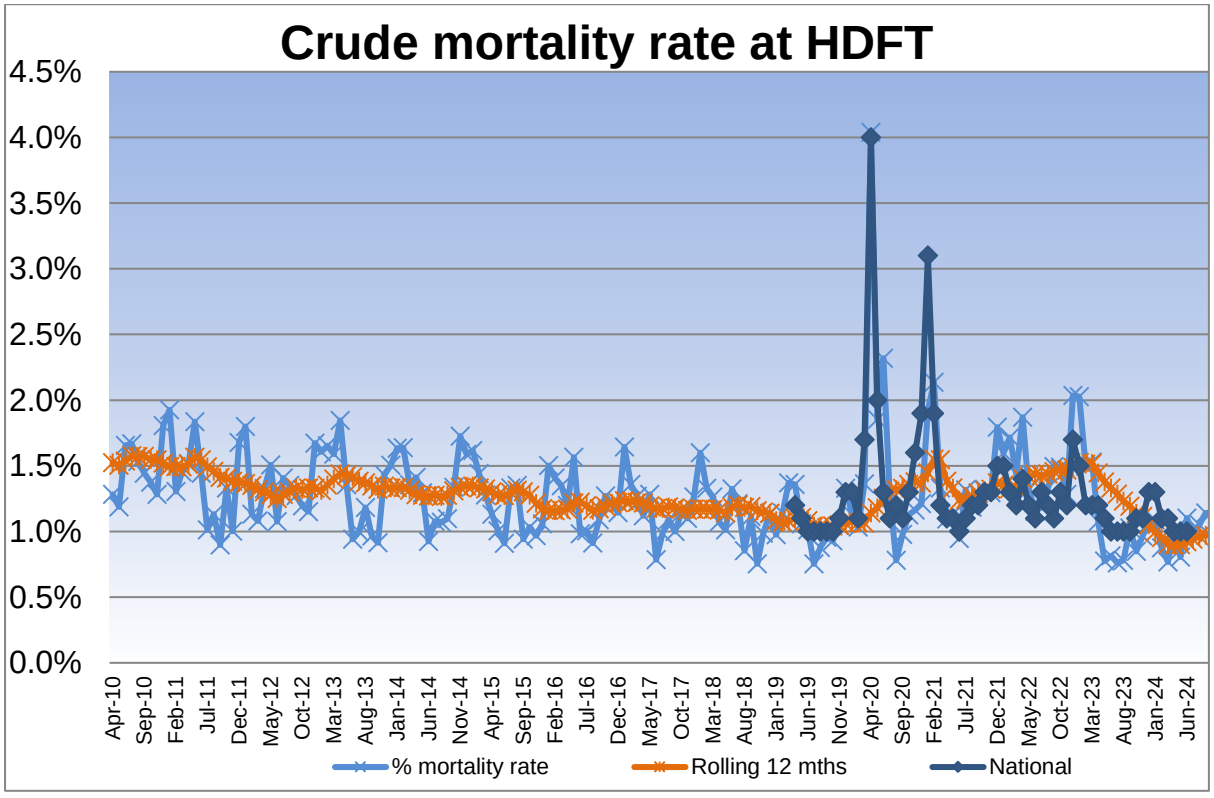

Figure 1: Crude mortality rates over the last 14 years (%deaths per hospital episode)

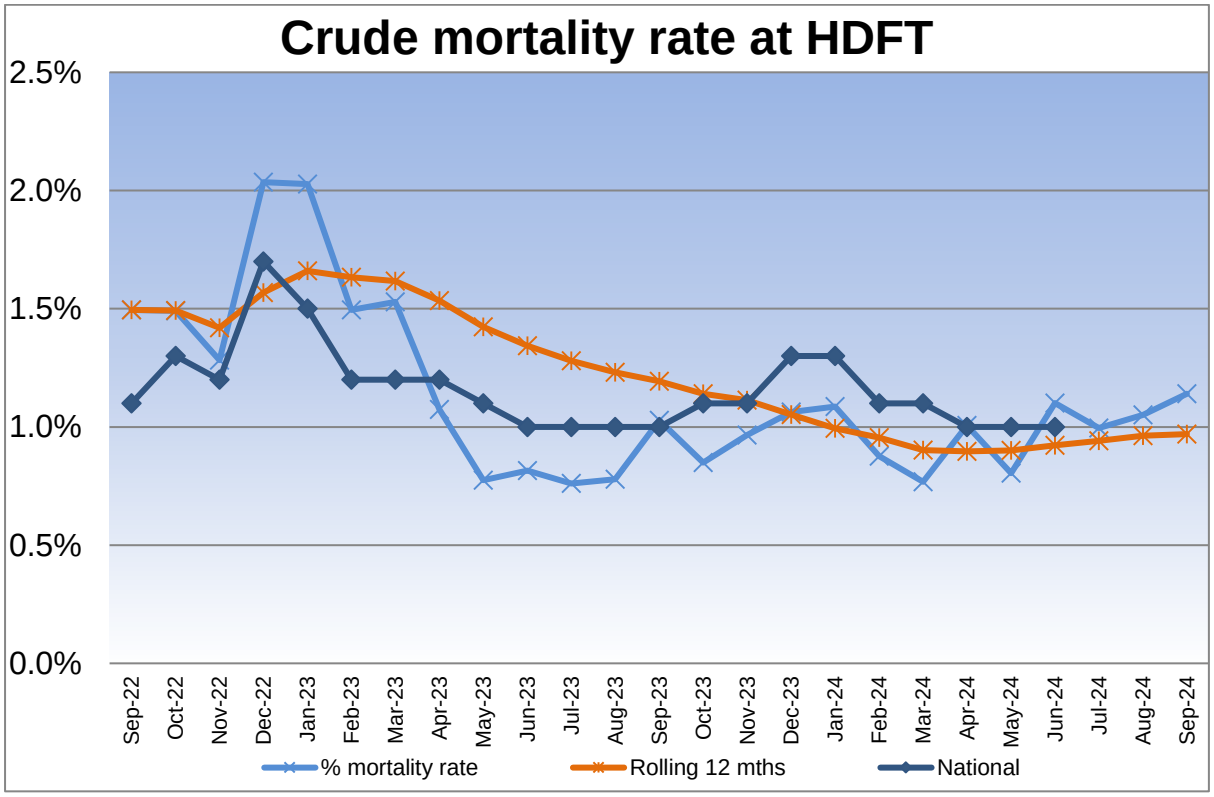

Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

Figure 3 shows a decline in SHMI from a peak in April 2022.

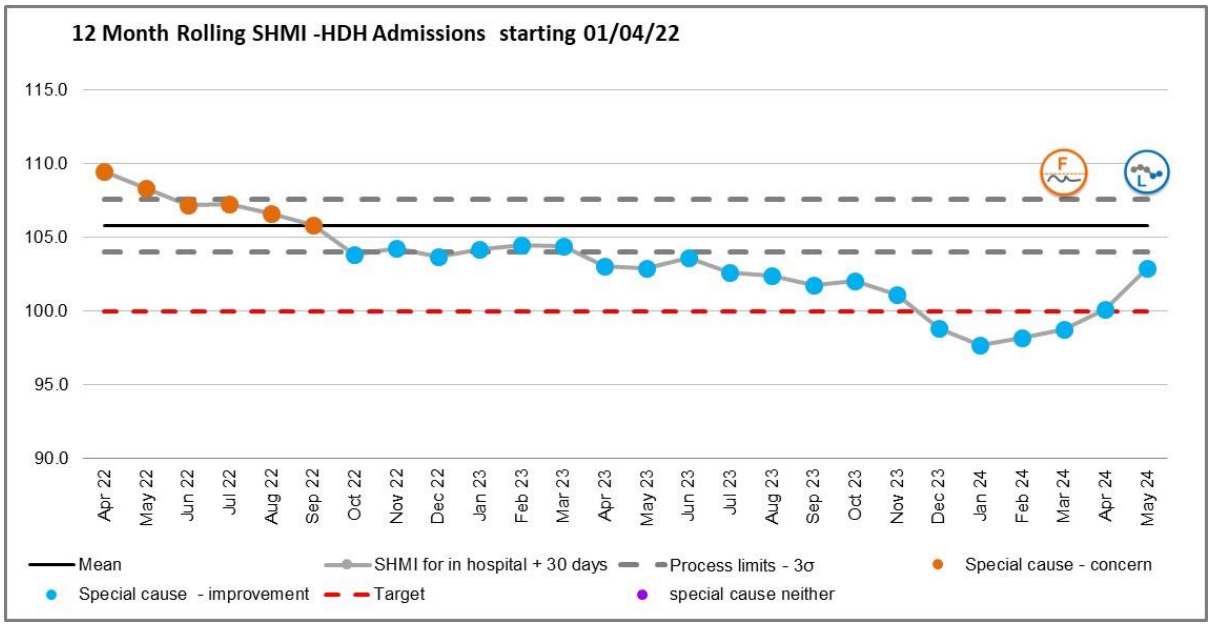

Figure 3: HDFT SHMI since April 2022

Figures 4 and 5 demonstrate the observed and expected death predicted by the SHMI model, with Figure 6 demonstrating the difference between these two values. The number of observed deaths rose to a peak in March 2023 whereas the expected numbers peaked in November 2023.

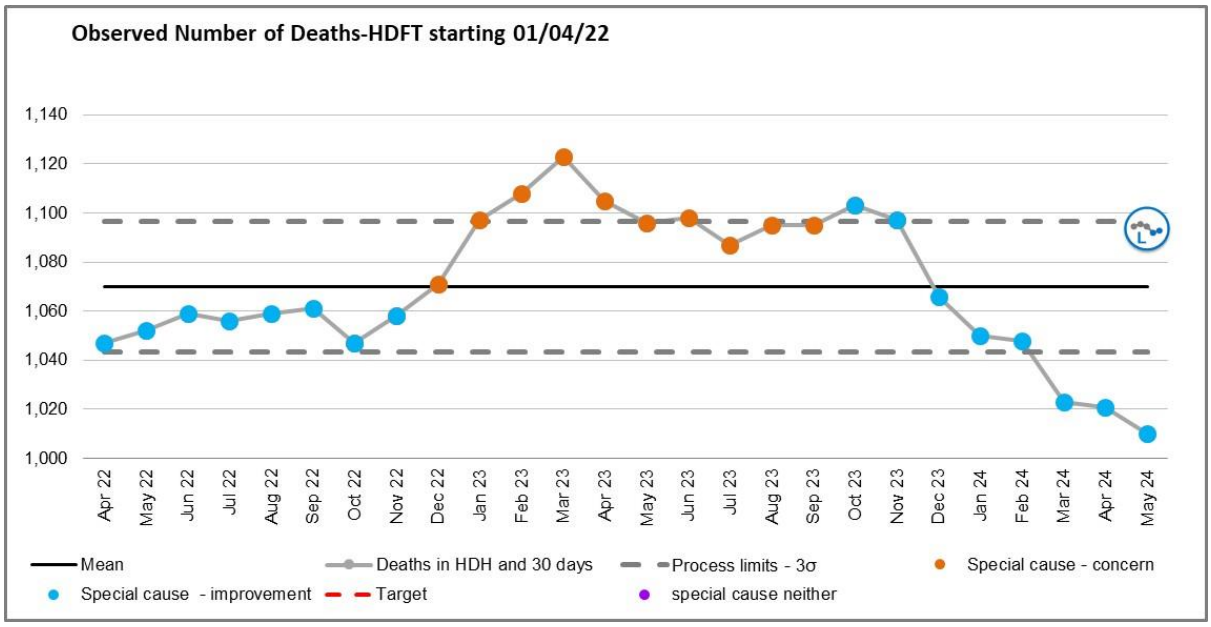

Figure 4: Observed deaths included into SHMI

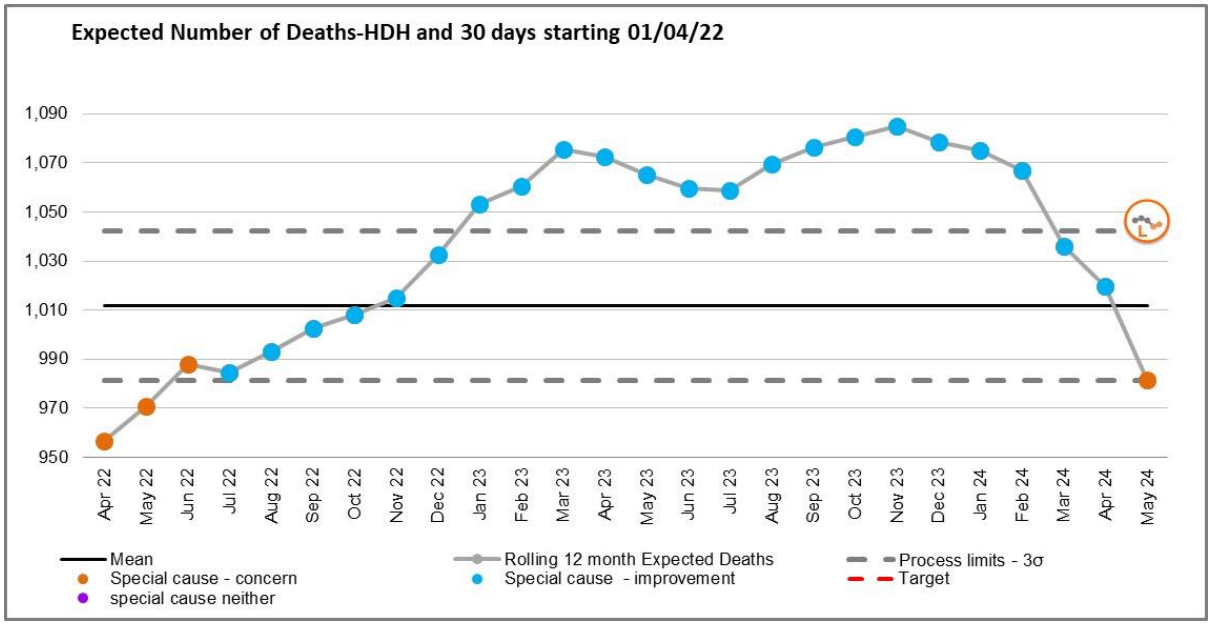

Figure 5: Expected deaths as predicted by SHMI.

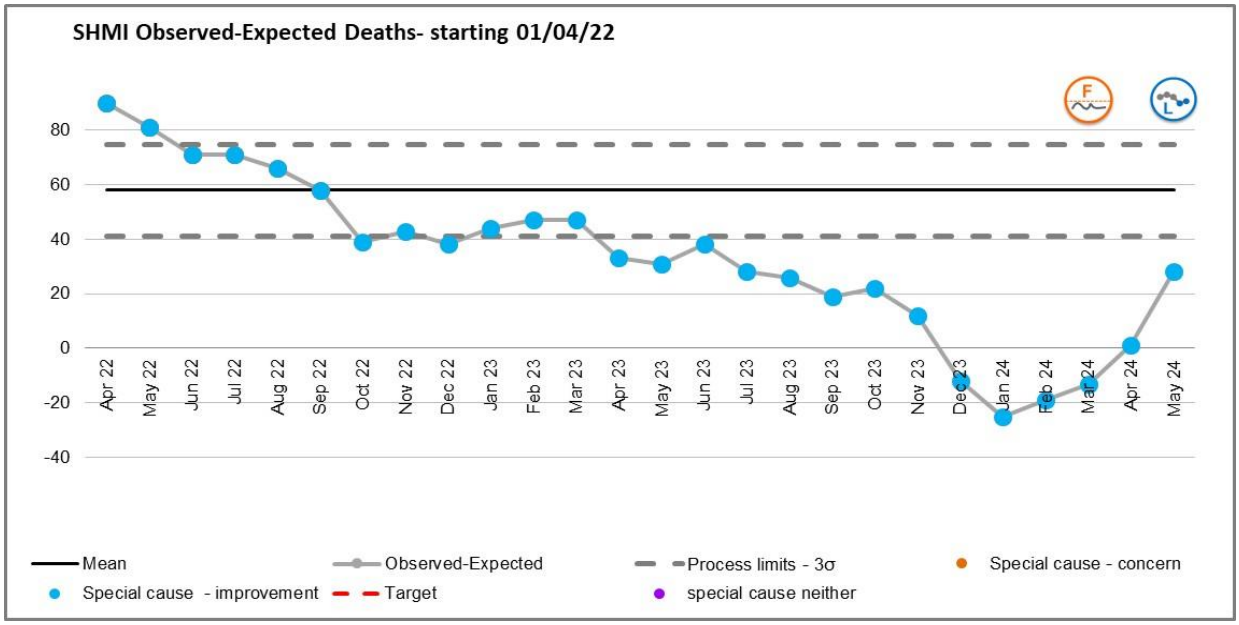

Figure 6: Observed-Expected Deaths, as predicted by SHMI

Figures 7 and 8 demonstrate our 12 month rolling SHMI against that of national peer and regional trusts:

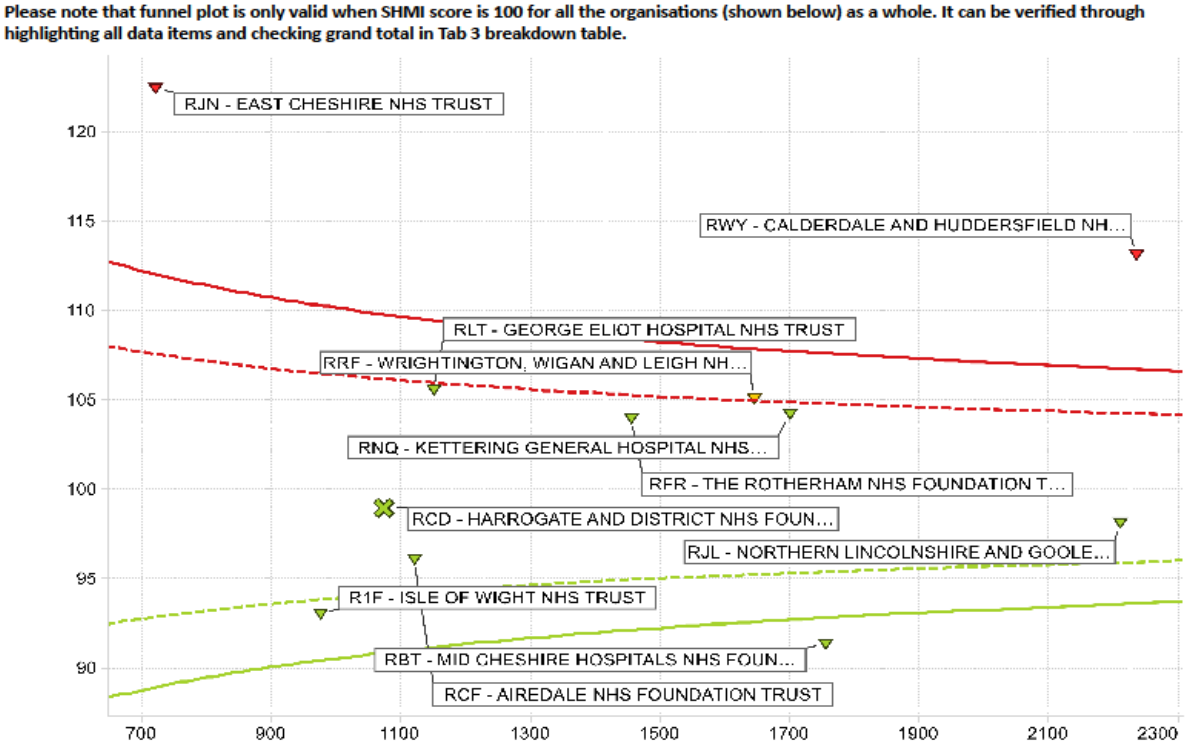

Figure 7: SHMI data for national peer organisations

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

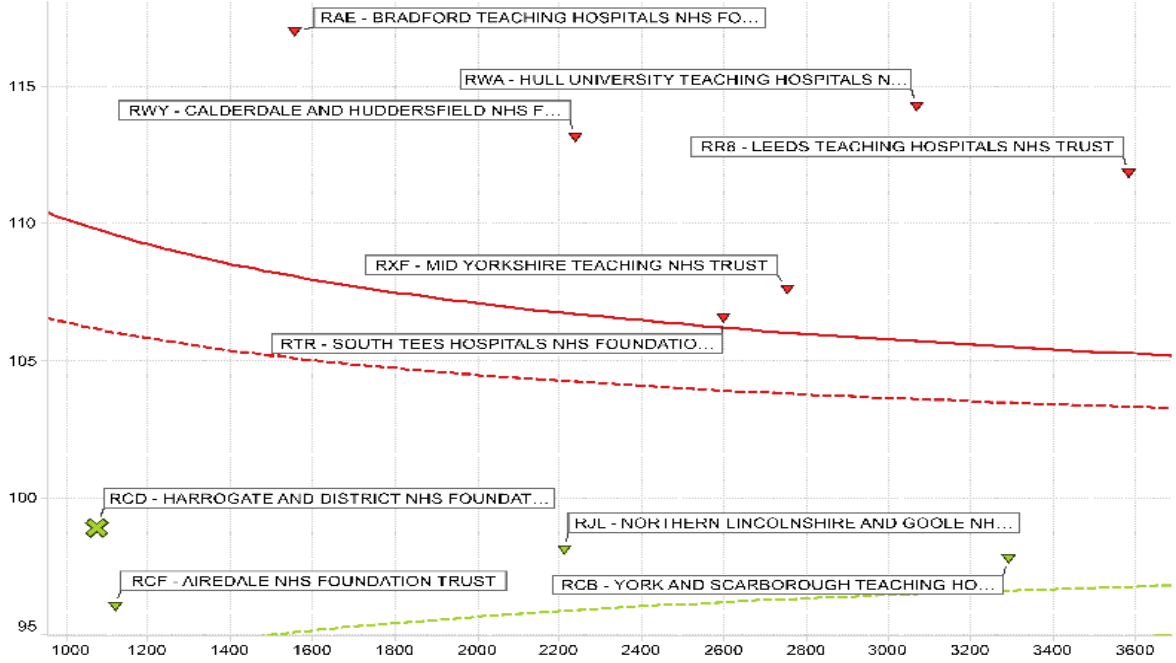

Figure 8: SHMI monthly data for regional peer organisations

3.3 Structured judgement reviews (SJR)

19 cases have been reviewed in this quarter with 13 relating to deaths in this period, 5 from the preceding Q4 and one from December 2023.

We have only received 1 “amber alert” for a diagnostic category with possible excess mortality in this quarter – deaths categorised as being due to “congestive heart failure”. This is a diagnostic area which has previously between explored with no concerns identified. We are currently finalising “business rules” as to when such intermittent alerts would trigger a more in-depth exploration of clinical cases.

In this quarter, cases chosen and reviewed by the Acute Medical team have been included. They have selected cases that they have already identified as having possible lapses in care and therefore this quarter has a higher number of episodes of poor care identified than previously (where a higher proportion of cases for review were selected at random).

2 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process. Feedback on their findings will be provided in subsequent papers when the reports are received.

All cases in this quarter were reviewed using the new Datix iCloud SJR module which uses the most up-to-date national question set. New questions include a subjective assessment of the avoidability of death – if this were deemed to be higher than 50:50 then a Patient Safety Incident Investigation (PSII) would usually be initiated. A second new field is whether there were gaps in clinical care, organisational aspects or both. In this quarter, organisational aspects noted were delays in admissions from the Emergency Department and failure to be reviewed by a consultant within 14 hours of admission.

The overall assessment of the standard of care of is shown in Table 1:

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical and Organisational score (NCEPOD)	Overall Care
13/06/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
12/12/2023	Good care	Adequate care	Slight evidence of avoidability	Room for improvement in organisational care	Good care
02/07/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
06/06/2024	Adequate care	Poor care	Definitely not avoidable	Room for improvement in clinical and organisational care	Poor care
02/06/2024	Poor care	Not Applicable	Possibly avoidable but not very likely (less than 50:50)	Room for improvement in clinical care	Poor care
29/07/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
19/08/2024	Good care	Good care	Definitely not avoidable	Good practice	Excellent care

02/06/2024	Poor care	Good care	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Good care
23/08/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
15/07/2024	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
05/07/2024	Poor care	Poor care	Definitely not avoidable	Less than satisfactory (either area)	Poor care
27/08/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
17/07/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
31/07/2024	Adequate care	Poor care	Definitely not avoidable	Room for improvement in clinical and organisational care	Adequate care
04/09/2024	Good care	Excellent care	Definitely not avoidable	Room for improvement in clinical care	Good care
30/06/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
08/07/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
05/09/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
14/09/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care

Table 1: Cored details of the cases reviewed this quarter

Three cases had overall care described as “poor”. All have been highlighted for a second review by a different clinician. One case, as a result of 2 SJRs, has been declared an PSII. A second case was felt to be adequate care by the second reviewer. The third case is still undergoing a review.

End of Life Care		
	24/25 Q1	24/25 Q2
Good care	12	11
Adequate care	4	2
Not Applicable	2	3
Poor care	1	1
Excellent care	0	2
tal	19	19

Patient Record Quality		
	24/25 Q1	24/25 Q2
Good	14	12
Adequate	5	6
Excellent	0	1
Total	19	19

Tables 2 and 3: End of Life Care provided and Quality of Patient Records

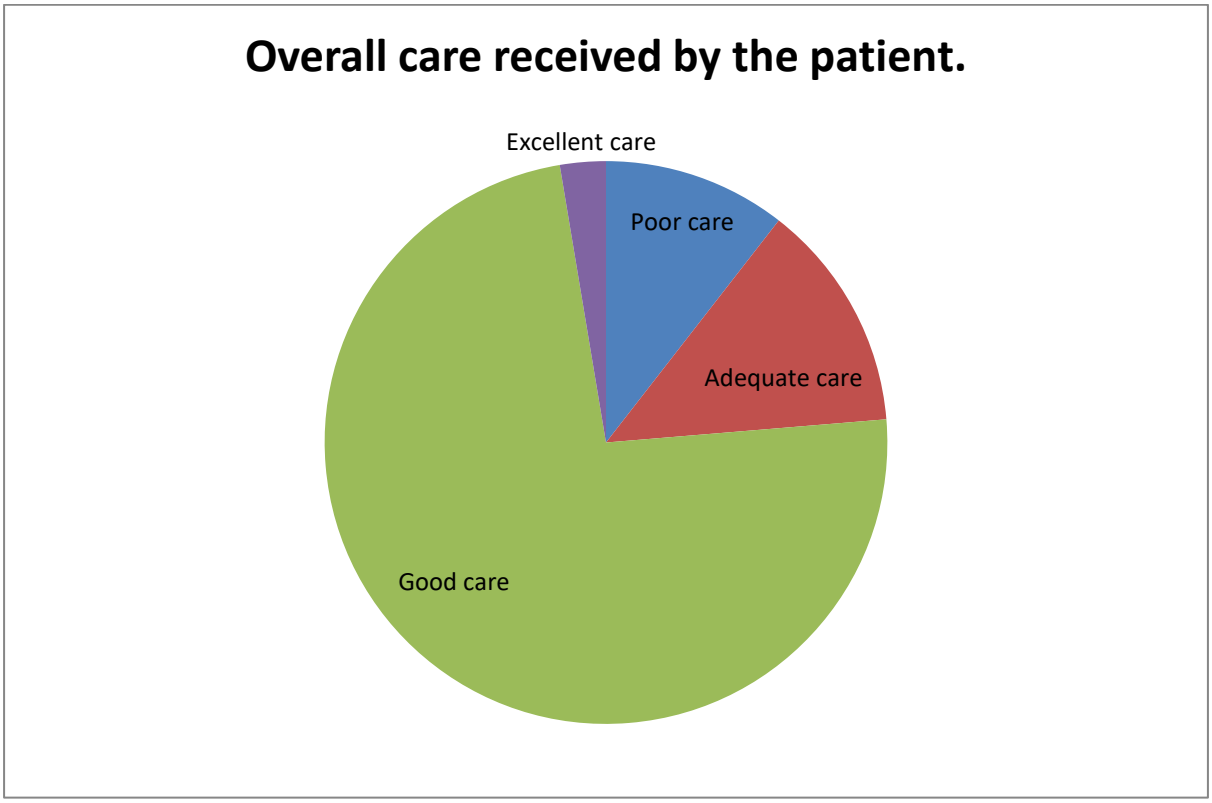

Figure 9: Overall care in all cases reviewed this financial year

Another new section of the Datix SJR is the ability for the review to identify any positive or negative learning points from the cases. These are shared with the clinicians via the regular Medical Directorate newsletter. Positive themes this quarter related to excellent use of the Critical Care Outreach team and strong communication with family members. Negative themes include early recognition of disease severity (especially in younger adults) and communications between clinical teams.

The Medical Examiner team have identified a possible theme related to early recognition and escalation of unwell patients. This will form a part of an ongoing PSII and will be the focus of some work by the Quality Team/Deputy Medical Directors.

4.0 Recommendation

The Board is asked to note the contents of this report and the processes for ensuring learning from deaths.