

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

TRUST BOARD – 24th February 2011

HSMR Update

EXECUTIVE LEAD	Dr Fraser – Acting Medical Director
CORPORATE OBJECTIVE	CO1 – Enhancing Patients experience, safety and effectiveness
EXECUTIVE SUMMARY	<p>As a result of a continuing elevated score for Hospital Standard Mortality for the Trust (113.7 presented to the Trust Board in Nov 10) the Medical Director tasked his team with</p> <ul style="list-style-type: none"> • Identifying what actions are currently being completed and by whom • Identifying what further actions are needed to not have avoidable deaths <p>It was identified that significant analysis had taken place to understand the Dr Foster figure including a review of 500 notes from Patients who had died in the Trust over the previous year. The indication pointed to the need for improvements in clinical coding processes which had been agreed and were being implemented from Aug 2010 onwards.</p> <p>As a result of these improvements there are early signs that the HSMR is reducing (89.9 for month Nov 10). However, due to the process of re-basing the Trust will have an elevated HSMR rate of approx 119 at the start of the next year.</p> <p>As such the focus needs to be increased and to include actions that will target a reduction of the crude rates of death in our Trust. By targeting crude rates of death we focus more on improving clinical activity and so Patient care and not just coding.</p> <p>These have been grouped into 2 areas:</p> <ul style="list-style-type: none"> • Systematic process for the review of deaths • Improvements to clinical pathways and activities <p>Many of the latter are already in progress or will shortly start under the LIPS programme. There is however, a strong consensus that we should improve the way we review deaths and collate information from these reviews in order to identify future actions. The governance for this work is proposed as the Quality and Safety Committee.</p>
RECOMMENDATION(S)	Trust Board is asked to NOTE the ongoing work

The Shrewsbury and Telford Hospital NHS Trust

Brief - HSMR Current Status and Future Actions

1. Introduction

In support of not having avoidable deaths and so reducing the HSMR, the task set by the Medical Director is to:

- Identify what actions are currently being completed and by whom
- Identify what further actions are needed to not have avoidable deaths

This brief aims to provide information on; the current status of the HSMR measure at SaTH, what actions have already been implemented or are in the process of being implemented, and finally what further actions are suggested.

2. Current Status of the HSMR Measure at SaTH

2.1. Previous Rates and Measurement methodologies

The Trust routinely monitored the HSMR using the Dr Foster tool from 2004 to 2006/07 with the measure being stable at 88-90. In 2007 a decision was made to cancel the Dr Foster contract and monitor crude death rates internally.

This did not take into account monitoring the trend in expected deaths which had fallen dramatically since 2008 leading to an elevated HSMR for 09/10.

This was reported to the Trust board on the 4th Nov by Adrian Osborne. The board agreed that we should track progress through the Quality and Safety Committee. The elevated rate was picked up by the SHA who wrote to the CEO in Nov 10. Tracey Lloyd drafted a letter for our response in late Nov 10.

The HSMR has been reported as being:

• 2007/08	104.8
• 2008/09	99.4
• 2009/10	117.5
• At trust board Nov 10 – measure from Aug 09 – Jul 10	113.7
• 2010/11 Quarterly Apr – Jun	110.8
• 2010/11 Quarterly Jul - Sept	105.3
• 2010/11 Quarterly so far Oct + Nov	91.6

As you can see the rate is reducing due to the improvements already implemented (see Para 3 below).

2.2. Impact of Re-basing

However due to the impact of re-basing the rate is predicted to rise for the 2010/11 year to approx 119 which will make SaTH an outlier nationally.

As such it is recommended that our focus on reducing avoidable deaths should continue in a structured way through the Mortality group.

2.3. Future Mortality Measure

As you are aware the intention within the NHS is to move to a different measure of mortality, The National Summar Hospital level Mortality Indicator, (SHMI), which is recommended to the National Review body to be implemented by Apr 2011.

There is a one day conference at The King's Fund on Tues 15th Mar on “reducing and measuring avoidable mortality in hospitals, including the new National Summar Hospital Level Mortality Indicator (SHMI)”

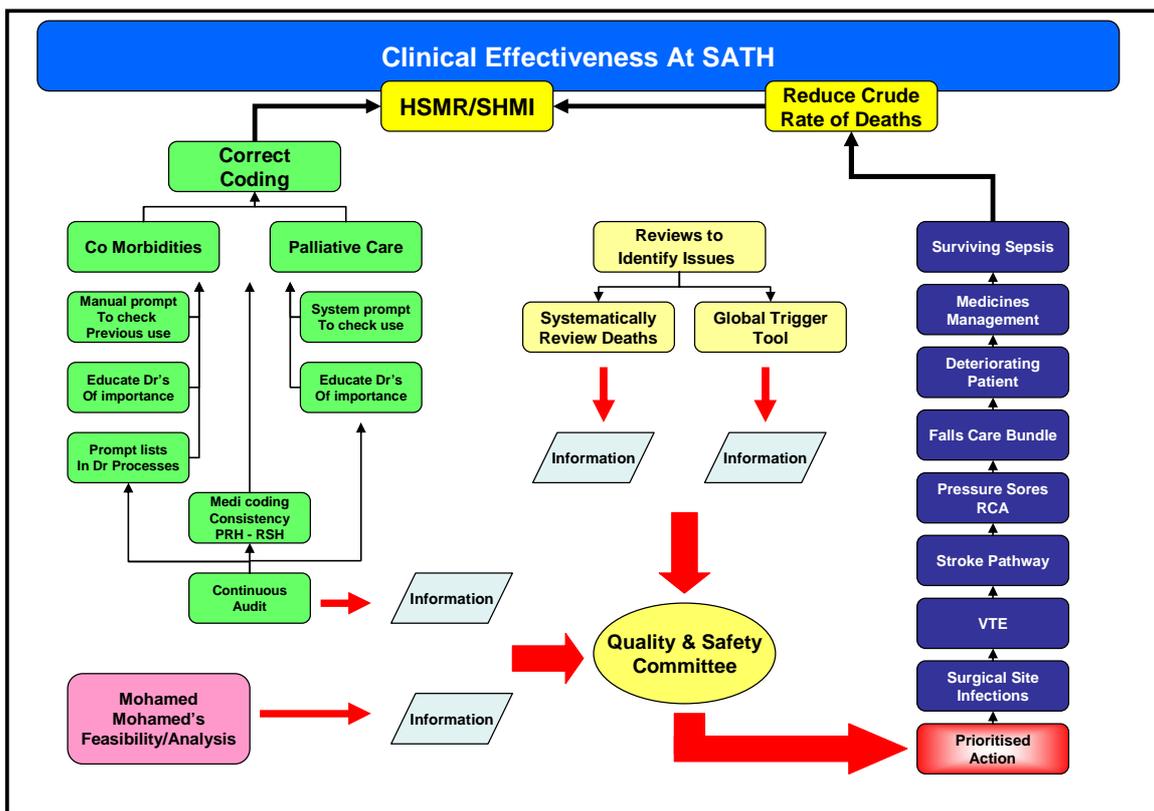
It is recommended that the Trust is represented at the conference.

3. Current Activity Supporting Avoidable Deaths

The work currently underway that will influence the HSMR can be grouped into 2 areas:

- Changes around clinical coding which directly affect the HSMR measure
- Changes that reduce the crude rate of deaths at SaTH and so indirectly affect the HSMR

The diagram below helps explain the context of various improvement activities.



3.1. Improvements in Coding

Dr MA Mohammed, a Senior Lecturer at Birmingham University has been conducting an exploratory desktop investigation into an increase in the hospital standardised mortality ratio for Shropshire and Telford NHS Trust Hospitals. His interim finding highlighted benefits to the Trust through improvements to clinical coding.

Much of the work has been previously coordinated by the HSMR Group set up in Apr 10, led by the Medical Director, and has focused on implementing improvements to clinical coding.

The improvements that have been implemented are

- Standardising the use of Medi-coding practices across both Hospital sites
- The appropriate use of the Palliative care codes where needed
- “End of spell” coding in order to improve the accuracy of coding
- Improvements to the coding of co-morbidities including:
 - The identification of co-morbidities within National guidelines
 - Manual prompt to ensure that co-morbidities in a previous spell are known so they are coded in the new spell
 - Monitoring of the use of co-morbidities to ensure continued correct use
- A system prompt to ensure appropriate use of Palliative care codes during coding process

Improvements are starting to be seen in the reduced HSMR measure for Nov 2010 which was at 89.9 and the general quarterly trend which is downwards.

In addition, some recent analysis conducted by Tracey Lloyd for some of the main diagnostic groups within Medicine, indicated a 5.4% improvement in coding Co-morbidities in Aug – Oct 2010 compared to the previous quarter Apr – Jun 2010. This resulted in an improvement to the relative risk (HSMR) of 7.6% for those specific diagnostic groups.

3.2. Future Improvements in Coding

A working group, facilitated by Pete Gordon and involving 3 Consultants and the Coding Managers are progressing further improvements to aid the coding of co-morbidities by Clinicians and coders. This includes communications to Juniors of the importance of coding and its impact, as well as the design of a simple form within Patients notes to aid the identification of co-morbidities. An initial version of the form is being trialed on Ward 7 at PRH.

3.3. Improvements Affecting the Crude Rate of Deaths

The improvements in this area fall largely within the; Leadership In Patient Safety (LIPS) programme, or other prioritised programmes directed at improving clinical effectiveness, Such as the Stroke Pathway and VTE improvements.

It is not thought appropriate to intervene in these initiatives as they are already being progressed within their own programme governance. However the HSMR group should understand their importance in reducing the crude rate of deaths within SaTH.

4. Systematic Review of Deaths

Work completed by Dr Mohamed recommends we need to understand more about why we have deaths to know if they were avoidable. This is also the consensus of those involved in the HSMR Group so far.

The implementation of the Global Trigger Tool, as part of the LIPS programme, is a significant step forward. The Global Trigger tool is a methodology that enables Patient records to be selected at random in order to detect incidents that may cause harm. It is not just to review deaths but any selected Patient record.

As such it is believed that SaTH should have a process for systematically reviewing our deaths in order to detect issues and eliminate avoidable deaths. The information from the reviews can then be fed into the Quality and Safety Committee is action is recommended.

4.1. Requirements for a Systematic Review of Deaths

The following is recommended in order to effectively review deaths in a systematic way:

- There should be a structured direction of what to review
- The elements of the review should be compared to clinical standards
- The business process of reviewing must be administered for the Clinicians
- Clear measures such as:
 - Was the clinical care appropriate and to known clinical standards
 - Is the Death certificate correct?
 - % of deaths reviewed
 - Was the coding correct?

It is suggested that how we should complete these reviews is discussed at the next Mortality Group meeting in Mar 2011 as it needs significant clinical input to a methodology to be effective.

4.2. General Points

At the T&W PCT board meetings recently the subject of the HSMR at SaTH was raised. The Board asked that an external investigation/validation be undertaken to determine the extent to which coding issues explained SaTH's last Dr Foster HSMR position.

The Medical Director talked on the phone with Dr Catherine Woodward from T&W PCT who is the HSMR lead for the PCT's and assured her of our seriousness in pursuing other non coding improvements in reducing HSMR.

5. Recommendations

The following are recommended

Recommendation	Decision/Owner
SaTH to send 2 people to attend the King's Fund conference on reducing and measuring avoidable deaths and new measure for mortality - SHMI. Date 15 th March	Medical Director (TL + JB Going)
Formalise Mortality Group with the following attendance: Dr Fraser, Mr Beacock, Dr Tuft, Clare Jowett, Tracey Lloyd, Angela Coles (Coding), Justin Barnes, Sam Cook (Coding Manager)	Medical Director (Starting Mar 2011)
Monitor progress of coding improvements by Coding working group	Sam Cook (Mortality Group)
The Quality & Safety Committee should be the body for prioritisation of possible improvement initiatives affecting HSMR	Medical Director (Presenting 18 Feb)
Implement a process for the systematic review of deaths across SaTH including key measures	Mortality Group