Trust Board Paper Q

To:	**Trust Board**
From:	Kevin Harris, Medical Director
Date:	**25 April 2013**
CQC regulation:	Outcome 16

Title:	UHL Quality and Safety Commitment – Saving Lives Update

Author/Responsible Director:
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Purpose of the Report:
Assurance

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	

Summary / Key Points:

The latest Summary Hospital Mortality Index (SHMI) covered the period July 11 to June 12 and UHL's SHMI was 105 which is above the national but is 'within expected' control limits.

UHL's Hospital Standardised Mortality Ratio (HSMR) for the financial year to date is 96.2 (April to Jan) and is anticipated to be 103 following the annual rebasing which is carried out by Dr Fosters at the end of each financial year upon receipt of all trusts' data.

Factors contributing to UHL's higher HSMR and SHMI are considered to be:

emergency admissions
pneumonia patients
patients at 'end stage' of their illness
palliative care admissions
'under coding' of co-morbidities.

Actions taken to improve in 12/13 are:

Stroke Pathway improvements (time to scan, direct admission to Stroke Unit)
Joined British Thoracic Society 'Pneumonia Care Bundle' project
Review of both crude and risk adjusted mortality rates at both Divisional and Trust level
Embedding of M&M Processes
Use of the Dr Fosters 'real time monitoring tool' to

Two priorities have been identified for action as part of the 13/14 Trust's Quality & Safety Commitment '

- Patients admitted at weekends or 'out of hours'
- Patients with a respiratory diagnosis (specifically pneumonia)

Additionally an 'interface review, involving both doctors and nurses from primary care and UHL, will commence in June looking at the deaths of patients who died in UHL or following discharge.

Next Steps

Optimising patient pathways to ensure early streaming of patients to the appropriate speciality
Implementation of the pneumonia care bundle
Formalising the process for reporting reviews of 'higher than expected' mortality rates
Investigating cost / benefit of purchasing the SHMI tool
Supporting the LLR Mortality Review.

Recommendations:

Trust Board Members are requested to receive and note the content of this report and to support the actions described therein.

Previously considered at another corporate UHL Committee?
SHMI and HSMR reported monthly via the Q&P Report
Also quarterly reporting to QAC

Strategic Risk Register:	**Performance KPIs year to date:**
See Risk 1 - BAF	SHMI Value - 105

Resource Implications (eg Financial, HR)

Yes – CQUIN funding to support implementation of the Respiratory Pathway

Assurance Implications

Yes - CQC Registration

Patient and Public Involvement (PPI) Implications

Regular public reporting to the Board

Stakeholder Engagement Implications:

LLR Interface Mortality Review

Equality Impact:

Data has been assessed with due regard to equality implications

Information exempt from Disclosure:
Patient identifiable information would not be disclosed

Requirement for further review?
Quarterly update to QAC & Trust Board as part of the Quality & Safety Commitment Reports

University Hospitals of Leicester NHS Trust

REPORT TO: Trust Board

REPORT FROM: Kevin Harris, Medical Director

REPORT BY: Rebecca Broughton, Head of Outcomes & Effectiveness

SUBJECT: UHL Quality and Safety Commitment – Saving Lives Update

DATE: 25th April 2013

1,0 Introduction

1.1 The Summary Hospital Mortality Index (SHMI) is the national indicator for measuring hospital mortality rates. The SHMI is updated on a quarterly basis and is reported as a '12 month rolling figure'.

1.2 The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a hospital over a defined 12 month period.

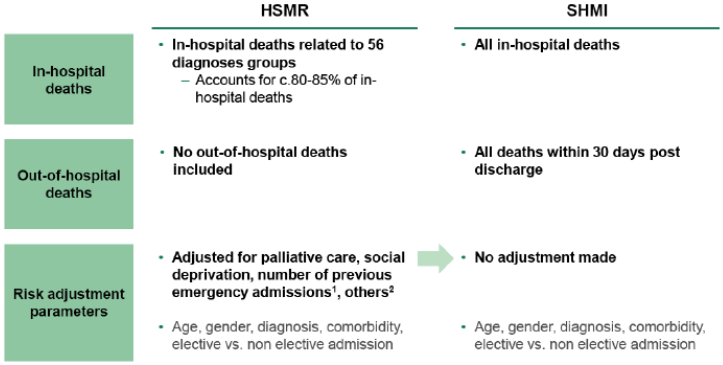
1.3 The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in hospital or within 30 days post discharge from the hospital.

1.4 The expected number of deaths is calculated from a risk-adjustment model developed for each diagnosis grouping that accounts for age, gender, admission method and co-morbidity.

1.5 Prior to the publication of the SHMI, risk adjusted mortality rates only looked at 'in hospital deaths', the most well known being the Dr Fosters "Hospital Standardised Mortality Ratio (HSMR).

1.6 The HSMR uses a similar methodology to the SHMI in order to calculate the ratio between the observed and expected number of deaths, taking into account patients' diagnosis, age, gender etc.

1.7 However, whilst the SHMI includes all activity and deaths, the HSMR is made up of 56 main diagnostic groups which account for 80% of all deaths. Also the SHMI risk-adjustment model also does not adjust for 'palliative care'.

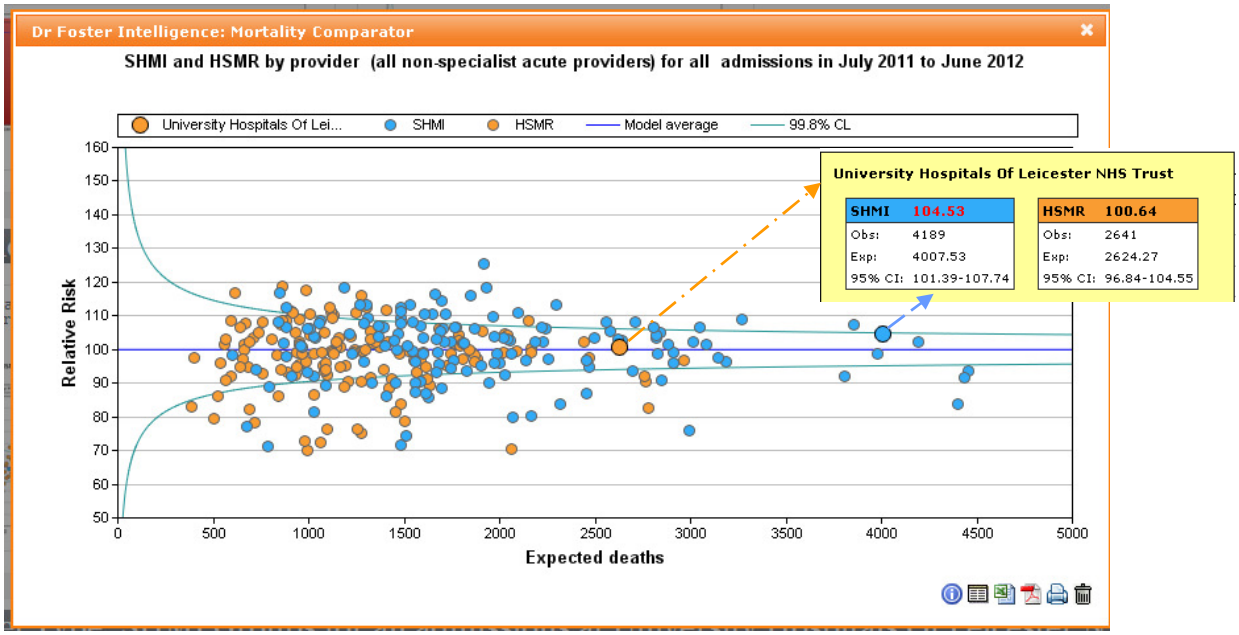


1.8 The SHMI for each trust was first published on the NHS Information Centre website in October last year and covered the period of April 2010 to March 2011.

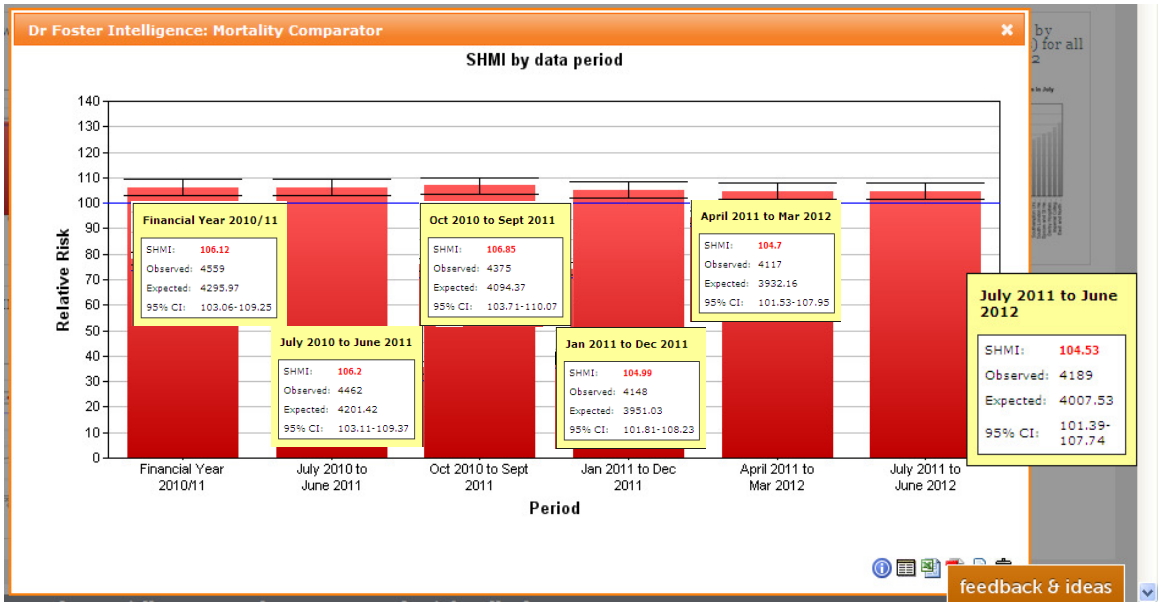
1.9 The Dr Foster HSMR is published for all trusts on an annual basis in the 'Good Hospital Guide' and until recently was also published on the NHS Choices Website.

2.0 SHMI

2.1 The latest SHMI covered the period July 11 to June 12 and UHL's SHMI was 105 which is above the national but is 'within expected' control limits.



2.2 Whilst our SHMI has remained at 105 for the last 3 'rolling 12 month figure', there has been a small incremental improvement with each published SHMI.

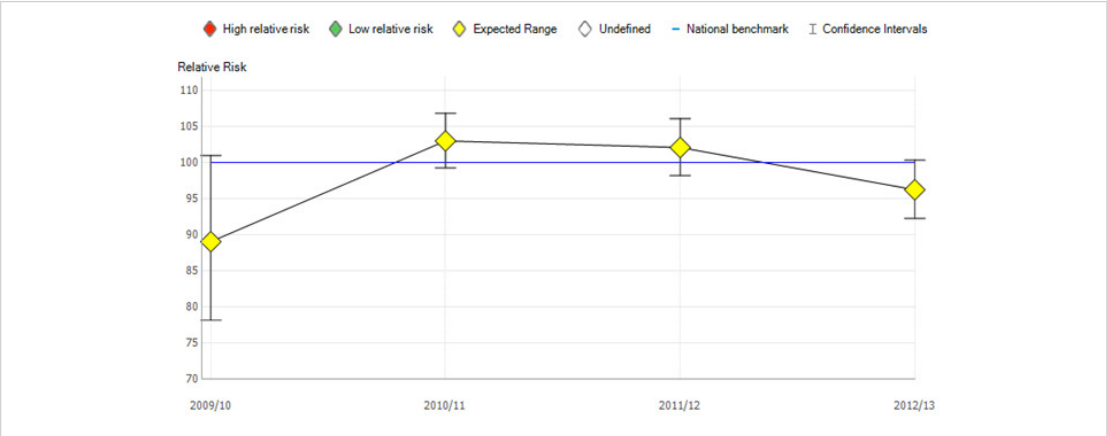


2.2 The next SHMI will be published in April and will cover the period October 11 to Sept 12. It is anticipated that our SHMI will remain the same.

3.0 HSMR

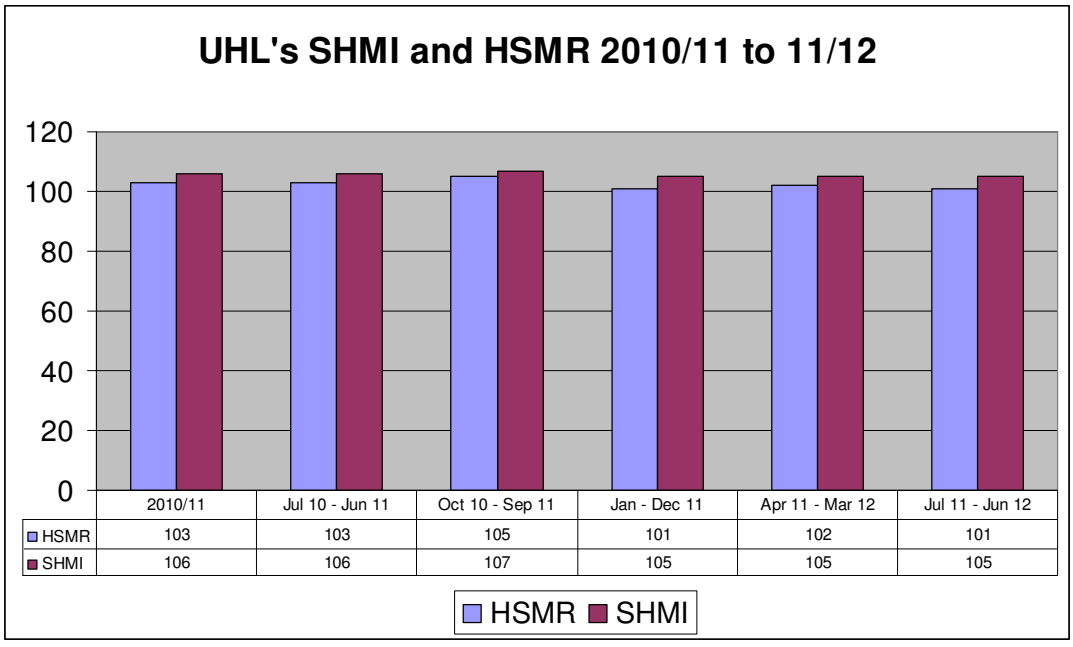
3.1 The trust's final HSMR has been above 100 following rebasing since 2009/12 but has always been 'within expected'.

3.2 UHL's HSMR for the financial year to date is 96.2 (April to Jan). However, it is anticipated to be 103 following the annual rebasing which is carried out by Dr Fosters at the end of each financial year upon receipt of all trusts' data.



4.0 UHL's HSMR and SHMI

4.1 Although there are differences between the SHMI and HSMR methodologies, the two results appear to be closely linked. The HSMR has always been slightly below the SHMI which is primarily due to exclusion of the palliative care adjustment and the inclusion of 'out of hospital deaths' in the SHMI.



4.1 Factors contributing to UHL's higher HSMR and SHMI are considered to be:

- high proportion of emergency admissions (as apposed to elective). Emergency admissions have an associated increase in mortality, especially patients admitted 'out of hours'.

- large proportion of deaths in patients attributed to pneumonia which has a recognised high mortality rate

- a significant number of deaths in patients at the 'end stage' of their illness and who have either not had an 'end of life pathway' implemented or this has not been followed

- provision of day case palliative treatments in the Cancer Centre and these patients will then be included in our SHMI even if they die in LOROS or at home

- 'under coding' of co-morbidities due to non availability of patients' case notes in time to meet the clinical coding deadlines. This then affects the calculation of the risk adjustment in both the SHMI and HSMR models.

5.0 Actions taken in 2012/13 to improve UHL's SHMI and HSMR

5.1 Improved the pathway for patients admitted with stroke, in line with NICE Guideline. CT scans carried out within an hour of arrival for 'high risk' patients and direct admission to the Stroke Unit.

5.2 Joined the British Thoracic Society 'Pneumonia Care Bundle' project to reduce delays in the accurate diagnosis of pneumonia and ensure earlier treatment.

5.3 Participation in the Heart Failure GOAL in the international Dr Foster Global Comparators project focused on the implementation of a Discharge Care Bundle. This includes patient education and discharge advice to support better self-management once patients are discharged.

5.4 Review of both crude and risk adjusted mortality rates at both Divisional and Trust level on a monthly basis.

5.5 Each speciality has embedded their processes for undertaking mortality and morbidity reviews to include acting on any learning outcomes and checking of clinical coding.

5.6 Use of the Dr Fosters 'real time monitoring tool' to identify specific diagnostic or procedural groups with higher than expected mortality rates and carrying out actions to improve, where applicable (coding was the key contributing factor in most instances).

5.7 Commissioned external review of UHL's SHMI and other mortality data to inform the Quality and Safety Commitment.

6.0 Quality & Safety Commitment – Reducing Mortality

6.1 Following the external in-depth analysis, which also looked at diagnostic groups, two priorities were identified for action as part of the 13/14 Trust's Quality & Safety Commitment '

- Patients admitted at weekends or 'out of hours'
- Patients with a respiratory diagnosis (specifically pneumonia)

6.2 These were therefore identified as priorities to be taken forward by the 'Saving Lives Quality Action Group':

6.3 'Out of Hours'
- Implementation of the 'Hospital 24/7'
- Implementation of 'Right Place' and earlier senior review of emergency admissions
- Further analysis of the 'out of hours' mortality data by site and diagnosis to identify priority subgroups

6.4 'Respiratory Pathway'
- Multidisciplinary and Primary/Secondary Care meeting held and proposed pathway agreed which will see increased number of patients admitted directly to Glenfield Hospital.

- Further work being undertaken to feed pathway into the Right Place workstream and to liaise with GPs and EMAS

- Improving patient pathway for pneumonia patients has been agreed as one of the 13/14 CQUIN Schemes.

7.0 LLR Mortality Summit

7.1 One of the SHMI work-streams has been to review the SHMI as a health community in collaboration with the LLR CCGs and Public Health and a joint LLR /UHL SHMI report has been previously presented to the GRMC.

7.2 Similar to previous findings, this joint review, found there was no correlation between the UHL SHMI and percentage of deaths that occurred outside hospital, the use of palliative care coding or the percentage of elective and non-elective admissions. Neither did there appear to be any statistical difference between mortality for City and County patients

7.3 Part of the report included findings from analysis of ONS and Hospital Mortality Data which identified that a third of the 'out of hospital deaths' occurred at home, a third were in 'care/nursing homes' and a quarter in community hospitals.

7.4 Further to the LLR collaborative review of UHL's SHMI, lead by Public Health, a 'health community mortality group' has been established.

7.5 An 'interface review' has been agreed to take place (due to commence in June) which will look at the deaths of patients who died at the LRI following a cardiac arrest and also those patients that died post discharge, following transfer to a community hospital or care home (but where the home was not the patient's residence on admission)

7.6 The review will be carried out by a group of medical staff (both GPs and UHL Consultants) and a group of nursing staff (from GP Practices, Community Nursing Teams and UHL) and will involve looking at the standard of care provided.

7.7 The intention of the review is not to attribute events to death nor to establish whether the death was preventable or not but to ascertain the standard and acceptability of care both within UHL and primary care.

8.0 Next Steps

8.1 Optimising patient pathways to ensure early streaming of patients to the appropriate speciality including to those specialities not on the main emergency site (LRI) – specifically respiratory patients

8.2 Implementation of the pneumonia care bundle which will be supported by the appointment of Pneumonia Nurses and the Virtual Respiratory Clinic for patients managed at the LRI site.

8.3 Formalising the process for reporting reviews of 'higher than expected' mortality rates for specific diagnostic groups via the Quality Assurance Committee

8.4 Investigating cost / benefit of purchasing the SHMI tool from University Hospitals of Birmingham's Hospital Informatics Department to enable linkage with UHL's own dataset at patient level.

8.5 Supporting the LLR Mortality Review and acting on the findings accordingly.