Mortality Strategy 2018-19
4 March 2019
### Trust Board

<table>
<thead>
<tr>
<th><strong>Meeting Date:</strong></th>
<th>4 March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong></td>
<td>Mortality Strategy 2018-19</td>
</tr>
<tr>
<td><strong>Purpose of the Report:</strong></td>
<td>Recommend to Trust Board to Approve</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
<td>This strategy is designed to ensure that the organisation (The Royal Wolverhampton NHS Trust) is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care</td>
</tr>
<tr>
<td><strong>Recommendation:</strong></td>
<td>To receive, review and approve</td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
<td>Approve</td>
</tr>
<tr>
<td><strong>Clinical implications and view</strong></td>
<td>Reviewed at Mortality Strategy Group, TMC</td>
</tr>
<tr>
<td><strong>Patient, carer, public impact and views</strong></td>
<td>Reviewed at Mortality Strategy Group and an action plan developed which is included in the document</td>
</tr>
<tr>
<td><strong>Resource implications</strong></td>
<td>SHIM recognised to be higher than average and the strategy is indeed to focus resources to ensure improvement of ratio.</td>
</tr>
<tr>
<td><strong>Author + Contact Details:</strong></td>
<td>Tel 01902 704957 <a href="mailto:jake.botfield@nhs.net">jake.botfield@nhs.net</a></td>
</tr>
<tr>
<td><strong>CQC Domains</strong></td>
<td><strong>Safe:</strong> patients, staff and the public are protected from abuse and avoidable harm. <strong>Effective:</strong> care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. <strong>Responsive:</strong> services are organised so that they meet people’s needs.</td>
</tr>
<tr>
<td><strong>Trust Strategic Objectives</strong></td>
<td>1. Create a culture of compassion, safety and quality 3. To have an effective and well integrated local health and care system that operates efficiently 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators</td>
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<tr>
<td><strong>Links to Assurances</strong></td>
<td>n/a</td>
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<tr>
<td><strong>Resource Implications:</strong></td>
<td>SJR completion resources</td>
</tr>
<tr>
<td><strong>Equality and Diversity Impact</strong></td>
<td>n/a</td>
</tr>
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<td><strong>Risks:</strong></td>
<td>To improve our mortality ratio</td>
</tr>
<tr>
<td><strong>Risk register reference:</strong></td>
<td>It’s on the BAF</td>
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<tr>
<td><strong>Other formal bodies involved:</strong></td>
<td>n/a</td>
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<tr>
<td><strong>References</strong></td>
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</table>
A significant amount of work has been undertaken during the year 18/19 to improve patient outcomes and this section summarises the most important projects.

**Quality Improvement Plan**

The Medical Director along with the Divisional Medical Director and Chair of the Mortality Review Group and Chief Nurse have been developing an improvement plan based on the requirements from the Learning from Deaths guidance, outcomes from external reviews and internal reviews of both case notes and diagnostic pathways analysis. The quality improvement plan will focus on 7 themes:

- Overall Programme Management
- City Wide Programme Approach
- Standardised Policy and Processes
- Quality and Safety of Care
- Education
- Workforce
- Communication plan

**End of Life/Palliative Care Pathways**

Providing comprehensive End of Life/Palliative Care pathways across the city is important to ensure that structures are in place to facilitate end of life/palliative care patients having their clinical needs met whilst remaining at home or in the community, without having to inappropriately be transferred to the Acute Trust for ongoing management when this is not necessary.

The intention is that patient will be managed in the community and only transferred acute care when their clinical condition mandates/requires this. Implementing this structure and then supporting pathways of care will be a significant improvement for end of life experience for both patients and family.

A city-wide group (Mortality Improvement Group) with representation form RWT, CCG and Primary care and Public Health has been set up to oversee and review mortality related issues and statistics across the health economy.

**Engagement with Bereaved families/carers**

The National Quality board recently published guidance for NHS trusts on working with bereaved families and carers recognising the importance of engaging with families and how to learn when things go wrong. The guidance advises trusts on how they should support, communicate and engage with families following the death of patients in their care.

The intention is to appoint a bereavement nurse to improve overall support and experience for families alongside the role of the Medical Examiner. This role will be pivotal in ensuring that families and relatives are supported in the aftercare of their bereaved loved ones.

Evidence suggests that early and prompt interventions for high-risk individuals can facilitate grief coping strategies and can minimise the adverse consequences of grief. The bereavement nurse will be skilled in providing care to bereaved individuals and competent in providing compassionate and sensitive care with and alongside the support of the wider multi-disciplinary team.

**Review of Deaths Post Hospital Discharge**
At present the mortality reviews are limited to hospital deaths. However, around twenty-four percent of all deaths accounted for in the mortality statistics (SHMI) occur within thirty days of discharge from hospital.

Currently there is no established process of learning about the care provided or gaps in service for those who die outside of hospital. Discussion are underway with CCG to agree the methodology and funding for reviewing care provision in community and primary care for out of hospital deaths. The expectation is that by reviewing these cases jointly, the health system across Wolverhampton will benefit from shared learning with the potential that a rich body of information will become available to inform themes, identify service gaps and areas for development.

**Dedicated Mortality (SJR) Reviewers**

One of the key challenges is timely completion of mortality reviews. The intention is to have a dedicated group of trained reviewers who can undertake SJRs, mortality reviews for SHMI alerting diagnosis and RCA’s involving deaths. The time requirement for reviews will be resourced.

The new review process will be independent and help to reduce the workload for directorates who can concentrate on learning from reviews and investigations, and implement service changes.

**Accurate Recording of Administration Data**

Administrative data used in the mortality calculations does not accurately reflect the profile of patients admitted to the Trust, resulting in an elevated SHMI from a lower than expected mortality rate.

Acute medical clerking proforma was modified to enable capture primary diagnosis and co-morbidities during the admission episode. The Head of Clinical Coding is providing educational updates across all the clinical directorates, with a focus on the medical directorates, to ensure clinical documentation is as complete as possible, to enable primary and secondary diagnosis to be captured accurately, along with all relevant co-morbidities.

Recently undertaken clinical audits highlighted issues with documentation and recording of primary diagnosis for SHMI alerting diagnosis groups. Further education is being planned along with an initiative to facilitate closer working between physicians and coders, initially on the Medical Assessment Unit.
**Strategy Name:** Mortality Strategy 2019-2020  
**Version:** V1  
**Status:** Final  
**Author:** Chair of Mortality Group  
**Director Sponsor:** Medical Director

<table>
<thead>
<tr>
<th>Version / Amendment History</th>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td></td>
<td>February 2019</td>
<td>Dr Viswanath</td>
<td>Introduction of Strategy</td>
</tr>
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</table>

**Intended Recipients:** All clinical staff with an influence to reduce mortality ratios.  
Governance teams  
Coding teams

**Consultation Group / Role titles and Date:** Mortality Review Group (MRG)

**Name and date of Trust level committee where reviewed**  
Trust Management Committee  
February 2019

**Name and date of final approval committee**  
Trust Board, March 2019

**Date of Policy issue**  
March 2019

**Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)**  

**Training and Dissemination:** Dissemination electronically through medical director to clinicians, senior nursing group, management teams including coding team

**To be read in conjunction with:**  
1. Trust Quality Account 2017/18  
2. The Royal Wolverhampton NHS Trust Medical Certificate and Learning from Deaths Policy OP87

**Equality Impact (initial) Assessment (all policies):** Completed Yes / No  
**Full Equality Impact assessment (as required):** Completed Yes / No / NA

**Contact for Review**  
Dr Viswanath, Consultant

**Implementation plan / arrangements (Title of Implementation Lead)**  
The Mortality Strategy Action Plan. Overall lead is the Medical Director

**Monitoring arrangements and Committee**  
This strategy will be monitored via the Quality Improvement Programme Board (Mortality)

**Document summary / key issues covered:**
This strategy describes how the organisation is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care.

**VALIDITY STATEMENT**
This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.
Mortality Strategy 2019-2022

This strategy is designed to ensure that The Royal Wolverhampton NHS Trust is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care.
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1. Executive Summary (Strategic Aim)

1.1. This strategy is designed to ensure that the organisation is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care.

2. Links to Trust's strategic objectives

2.1. Strategic Objectives

This strategy supports the delivery of the following Trust strategic vision and objectives:

- To be an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve;
- Create a culture of compassion, safety and quality;
- Proactively seek opportunities to develop our services;
- To have an effective and well integrated local health and care.

2.2. Scope

This strategy sets out a foundation for The Royal Wolverhampton NHS Trust describing the characteristics that influence the mortality statistics and prospectively outlining the programmes of work that will provide assurance regarding the quality of care provided within the organisation.

This strategy has been developed collaboratively through key members of the Mortality Review Group including senior medical, nursing and administrative colleagues across the Trust. Progress against key milestones will be monitored through the Quality Improvement Programme Board-Mortality.

The strategy links with other work programmes being undertaken across the Trust including the 7 day service agenda and End of Life Care.

The strategy should be read in conjunction with OP87, Medical Certificate Completion and Learning from Deaths.


3.1. Over the last decade there has been increased scrutiny of national mortality rates within healthcare organisations, leading to some high-profile investigations identifying failings in the governance around mortality reviews; such as care deficiencies within The Francis Report. Around fifty percent of all deaths occur in hospital and most of these are inevitable; in a study by Hogan et al around 3–5% of acute hospital deaths were deemed to be potentially preventable. Determining avoidable or preventable mortality is challenging for a variety of reasons and currently there is no nationally validated methodology.
3.2 There is no evidence linking hospital standardised mortality ratio with care quality\(^2\), and other contributing factors such as data coding, severity of illnesses, admission pathway, end of life care provision, and local population characteristics should be taken into consideration when reviewing hospital mortality statistics.

3.3 The National Mortality Case Record Review Programme (NMCRR)\(^3\), delivered by Royal College of Physicians offered training to acute hospital doctors in the use of a standardised and validated case note review method called Structured Judgement Review (SJR). The SJR approach to mortality reviews allow for both quantitative and qualitative information on care to be reviewed. The Royal Wolverhampton NHS Trust (RWT) has actively adopted the SJR methodology across all specialities.

3.4 Trust Boards need assurance that deaths are reviewed and that opportunities to improve care for future patients are not missed. The Care Quality Commission’s publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, ‘Learning, candour and accountability’ builds on the need to maximise learning from deaths\(^4\).

3.5 The subsequent publication of the National Quality Board National Guidance on Learning from Deaths\(^5\) and the Child Death Review\(^6\) has further extended the recommendations made and statutory guidance required of Trusts, so that clinical reviews and Learning from Deaths happen to enable maximum learning to take place.

3.6 Concentrating attention on the factors that cause deaths through learning from mortality will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient. There will also be an associated positive impact on the experience of patients’ families and carers through better support and opportunities for involvement in investigations and reviews.

3.7 This strategy will provide a framework for aligning systems, processes and quality improvement initiatives for the purpose of ensuring that the organisation is learning from mortality and engendering a culture of clinical excellence. It is a dynamic document which will be reviewed and developed over time.

3.8 This strategy outlines the Trust’s commitment to improving the outcomes for its patients and details the initiatives already undertaken by the Trust during 2018/19. It is the framework for identifying systems, processes and quality improvement initiatives for the purpose of learning from mortality in the future.
3.9. The key foci of work will be:

- Timely mortality reviews and/or RCAs to identify learning from deaths, which will include review of deaths post hospital discharge
- Lessons learnt are shared and linked to the quality improvement agenda
- Clinical pathways to deliver high quality care
- Engagement with bereaved families and relatives
- City wide implementation of End of Life Care in line with Gold Standard framework
- Accurate capture of administrative data during admission to reflect the population being treated through robust coding and documentation

The delivery of these strategies requires attention both to transactional processes such as documentation and coding, and to transformational change, embedding a culture of continuously monitoring quality of care.

A strategic plan that sets out the detailed programme of work is included in the Appendix.

4. Background- Summary

This section provides a summary of the factors that contribute to the measurement of mortality. Further detail relating to the definition of terminology used and potential rationale for the trends seen at RWT are included as an appendix, page 17 of this document.

4.1. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths. In England SHMI (Summary Hospital-level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio) are used to measure SMR. SHMI replaced HSMR as a national statistic in England and is reported quarterly by NHS Digital.

4.2. RWT is one of 35 Acute Trusts with a higher than expected SHMI and the second highest in England, (April 2017 to March 2018), see appendix, Fig 1.

4.3. There are several reasons why hospitals may have an elevated mortality ratio other than quality of care:

- Quality of Care;
- Pathways (admission and discharge);
- Local deprivation profile;
- Risk factors (un-modelled) in the population e.g. smoking, alcohol;
- End of life infrastructure and care for the dying in the community;
- Severity of illness of those admitted;
- Coding practices (primary diagnosis and co-morbidities);
- Place of Death (proportion dying in hospital).
4.4 RWT has worked extensively in an attempt to understand the reasons for the high SHMI and the change in trend. The key points are:

- Compared to similar Local Authorities (based on deprivation), Wolverhampton has a similar overall death rate;
- SHMI at RWT started to increase from the national average at about the time of the opening of the new Urgent and Emergency Care Centre (November 2015) and the subsequent redesign of pathways, including the introduction of a medical physician in the Emergency Department, the Physician A model (see appendix, Fig3);
- Emergency medical and Trust ordinary admissions have decreased at RWT since 2015, whilst the national trend is for an increase (see appendix, Figs 4-6);
- The calculated expected mortality of admitted patients has decreased at RWT in comparison to the national picture where the trend is for the calculated expected mortality to increase (see appendix, Fig 5 and 6);
- The number of admissions from those over 80 years of age has decreased, but the crude mortality for this age group has increased.
- Circulatory diseases, cancers and respiratory diseases are the top 3 causes of death in Wolverhampton (compared with other Local Authorities, Wolverhampton has a high overall death rate for alcohol related deaths);
- The Trust has one of the highest proportions of deaths occurring in hospital in the country, particularly for patients in age groups 0-64 and over 85 years, and a significantly lower proportion of deaths in a Hospice in people aged 0-64years (appendix, Fig 9-10);
- A key theme from clinical audits presented within the Trust is that coding of primary diagnosis is not always accurate;
- The Trust has a high number of FCE’s per hospital spell, which may impact on the accuracy of coding as the required clinical information may not be recorded within the first FCE, which is used to determine the primary diagnosis and co morbidities;
- Multiple audits of the clinical care provided for SHMI alerting diagnoses have been undertaken in the Trust within the last 2 years.

An understanding of the specific characteristics relating to mortality coding and presentation at RWT and within Wolverhampton, as well as the national learning from death guidance has informed the strategies that follow within this document.

5. Trust Mortality Strategy

5.1 The Royal Wolverhampton Trust is working to a strategy which is intended to provide assurance regarding the quality of care provided within the organisation.
5.2 The key strategic objectives are to ensure:
- Timely mortality reviews and/or RCAs to identify learning from deaths, which will include review of deaths post hospital discharge;
  - Lessons learnt are shared and linked to the quality improvement agenda;
  - Clinical pathways are used to deliver high quality care;
  - That there is accurate capture of administrative data during admission to reflect the population being treated through robust coding and documentation;
  - Engagement with bereaved families and relatives;
  - City wide implementation of End of Life Care in line with Gold Standard framework.

5.3 The delivery of these strategies requires attention both to transactional processes such as documentation and coding, and to transformational change, embedding a culture of continuously monitoring quality of care.

5.4 A robust Governance Mortality Framework is required to deliver the strategy.

6. Roles and responsibilities - Mortality Governance Structure:
The governance structures are represented below (Figure 1)
Mortality Review Group (MRG)

7.1 The Mortality Review Group oversees the mortality review process with senior clinical representation from all specialties. It is attended by colleagues from the CCG and Public Health for further oversight.

7.2 MRG monitors mortality data, trends and alerting diagnosis groups within the SHMI basket. Investigations are reported to the group both for data quality and clinical care. Findings are discussed within the multidisciplinary group.

7.3 Outputs from MRG are reported internally through the Quality Assurance Group and ultimately Trust Board.

8 Quality Improvement Programme Board- Mortality

This executive governance group meets monthly to oversee the quality improvement initiative work including receiving regular reports from developing initiatives such as the End of Life pathway, and Medical Examiner project.

9 Learning from Deaths (LfD)

9.1 Our approach to LfD has focused on understanding mortality data and providing assurance in relation to the clinical care provided to deceased patients.

9.2 National Guidance on LfD was published in March 2017 and recommended a consistent methodology for reviewing the care records of deceased patients to facilitate more focused learning from deaths. The Trust Mortality Policy (OP87) incorporates the recommendation from the national Learning from Deaths (LfD) guidance (below).

The Key components are Assessment & Learning to support Quality Improvement:
10 Medical Examiners

10.1.1 The Department of Health recognised the need for reform of the current death certification process based on the findings of the Shipman enquiry and proposed the introduction of Medical Examiners. It was subsequently legislated for in the Coroners and Justice Act 2009 to provide independent scrutiny of all deaths not referred to the coroner.

10.1.2 The Trust is introducing the Medical Examiner role to support the national LfD programme and as a quality improvement initiative in supporting bereaved relatives and improving the process and timeliness of issuing death certificates.

10.1.3 There are several benefits of the Medical Examiner model, including improvements in patient safety, an increase in the accuracy of death certification and a quicker identification of problems with care. Medical Examiners will address bereaved relatives’ concerns and reduce the number of “inappropriate” referrals to the Coroner.

10.1.4 The Trust has appointed Medical Examiners who will be based in a purpose-built Bereavement Centre alongside the administration team, bereavement nurse and Registrar for deaths. Initially the service will be from Monday to Friday from 9-5 pm with a view to extend the service over weekend once it is fully established.

10.1.5 This development will be a significant factor in improving the management of deaths for the organisation including the capacity to review deaths.

10.2 Structured Judgement Review (SJR)

10.2.1 The National Mortality Case Record Review Programme supported by the Royal College of Physicians developed a standardised approach to case record review for adult deaths in acute hospitals in England and Scotland.

10.2.2 RWT has adopted the SJR methodology, and training has now been rolled out across the organisation. The main aim of the SJR process is for clinicians to learn from aspects of care that could have been improved, even when death was inevitable, and to identify areas of good practice.

10.3 Stage 1 SJR

10.3.1 Introduction of Medical Examiners model will enable selection of appropriate cases for Stage-1 SJR. In addition to cases identified by the Medical Examiner, the following deaths will be reviewed:

- Deaths not subject to Medical Examiner scrutiny;
- Learning Disability/Mental Health deaths;
- Maternal, neonatal and child deaths (National programme);
- Elective admission deaths;
- DATIX incident or complaints;
- Deaths 30 days post discharge (selection);
- Random selection of 10% of deaths.
10.4 Stage 2 SJR

10.4.1 Cases identified as receiving poor or very poor care are escalated to a Stage 2 SJR, which is a more detailed assessment undertaken by 2 reviewers independently, assessing quality of care in more detail.

10.4.2 Cases triggering an SJR 2 are allocated within one month. Following completion of the stage 2 SJR, cases are referred to the Directorate for discussion at their Governance meetings and the learning from the deaths is then completed within the Directorates and Divisions. Learning and actions are shared with compliance/quality assurance committee and MRG to support trust-wide learning (Figure 16).
10.5 Investigation (RCA)

10.5.1 If significant omissions in care are noted during reviews, they are escalated to serious incident status and will undergo a formal Root Cause Analysis (RCA). All deaths undergoing formal RCA (irrespective of how they are identified) will have avoidability determination as one of the outcomes of the investigation process.

10.6 Monitoring of Diagnostic Groups with Elevated SHMI

10.6.1 Those diagnostic groups with significantly elevated SMR’s are formally audited by case note review to assess overall quality of care review of any omissions in care and to assess whether deaths may be potentially avoidable. These reviews are undertaken by specialists in the diseased category. A coding review is also undertaken.

Figure 17 - The following diagnostic groups are currently subject to this process (April 2017 to March 2018):

<table>
<thead>
<tr>
<th>Diagnostic Group (CCS)</th>
<th>Expected no. deaths</th>
<th>Deaths in hospital or within 30 days</th>
<th>Deaths in hospital</th>
<th>No. Discharges</th>
<th>% Deaths in hospital</th>
<th>% Discharge with palliative care coding</th>
<th>Average comorbidity score per spell</th>
<th>Crude mortality rate</th>
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<tbody>
<tr>
<td>Influenza</td>
<td>459</td>
<td>7.84</td>
<td>36</td>
<td>29</td>
<td>234</td>
<td>81%</td>
<td>2%</td>
<td>9.6</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>325</td>
<td>4.92</td>
<td>16</td>
<td>14</td>
<td>146</td>
<td>88%</td>
<td>5%</td>
<td>6.3</td>
</tr>
<tr>
<td>Short gestation; low birth weight; and fetal growth retardation</td>
<td>239</td>
<td>8.78</td>
<td>21</td>
<td>21</td>
<td>494</td>
<td>100%</td>
<td>0%</td>
<td>0.1</td>
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<tr>
<td>Chronic ulcer of skin</td>
<td>237</td>
<td>5.07</td>
<td>12</td>
<td>10</td>
<td>89</td>
<td>83%</td>
<td>4%</td>
<td>10.5</td>
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<tr>
<td>Esophageal disorders</td>
<td>218</td>
<td>5.04</td>
<td>11</td>
<td>6</td>
<td>261</td>
<td>55%</td>
<td>2%</td>
<td>5.6</td>
</tr>
<tr>
<td>Other endocrine disorders</td>
<td>210</td>
<td>6.67</td>
<td>14</td>
<td>8</td>
<td>154</td>
<td>57%</td>
<td>4%</td>
<td>10.3</td>
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<tr>
<td>Other connective tissue disease</td>
<td>205</td>
<td>14.17</td>
<td>29</td>
<td>19</td>
<td>780</td>
<td>66%</td>
<td>1%</td>
<td>8.4</td>
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<tr>
<td>Other nervous system disorders</td>
<td>204</td>
<td>6.36</td>
<td>13</td>
<td>10</td>
<td>344</td>
<td>77%</td>
<td>3%</td>
<td>5.1</td>
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<tr>
<td>Skin and subcutaneous tissue infections</td>
<td>190</td>
<td>12.66</td>
<td>24</td>
<td>22</td>
<td>825</td>
<td>92%</td>
<td>1%</td>
<td>4.8</td>
</tr>
<tr>
<td>Peripheral and visceral atherosclerosis</td>
<td>189</td>
<td>9</td>
<td>17</td>
<td>17</td>
<td>50</td>
<td>100%</td>
<td>10%</td>
<td>9.9</td>
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<tr>
<td>Biliary tract disease</td>
<td>180</td>
<td>12.76</td>
<td>23</td>
<td>11</td>
<td>753</td>
<td>48%</td>
<td>2%</td>
<td>3.7</td>
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<tr>
<td>Congestive heart failure; nonhypertensive</td>
<td>142</td>
<td>95.35</td>
<td>135</td>
<td>115</td>
<td>644</td>
<td>85%</td>
<td>4%</td>
<td>11.4</td>
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<tr>
<td>Fluid and electrolyte disorders</td>
<td>143</td>
<td>30.37</td>
<td>43</td>
<td>31</td>
<td>376</td>
<td>72%</td>
<td>3%</td>
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<tr>
<td>Senility and organic mental disorders</td>
<td>139</td>
<td>49.49</td>
<td>69</td>
<td>57</td>
<td>399</td>
<td>83%</td>
<td>5%</td>
<td>12.3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>135</td>
<td>288.08</td>
<td>388</td>
<td>325</td>
<td>1601</td>
<td>84%</td>
<td>4%</td>
<td>12.7</td>
</tr>
<tr>
<td>Acute cerebrovascular disease</td>
<td>130</td>
<td>127.39</td>
<td>166</td>
<td>154</td>
<td>743</td>
<td>93%</td>
<td>4%</td>
<td>11.7</td>
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</tbody>
</table>

10.6.2 In addition, a programme of work is being set up which will ensure that these diagnostic groups will form part of a continuous quality improvement scheme.

10.6.3 Learning from audit and case note review will inform the requirements for change.
11 Developments 2018/19

A significant amount of work has been undertaken during the year 18/19 to improve patient outcomes and this section summarises the most important projects.

11.1 Quality Improvement Plan

11.1.1 The Medical Director along with the Chair of the Mortality Review Group and the Chief Nurse have been developing an improvement plan based on the requirements from the LfD guidance, outcomes from external reviews and internal reviews of both case notes and diagnostic pathways analysis. The quality improvement plan will focus on 7 themes:

- Overall Programme Management;
- City Wide Programme Approach;
- Standardised Policy and Processes;
- Quality and Safety of Care;
- Education;
- Workforce;
- Communication plan.

11.2 End of Life/Palliative Care Pathways

11.2.1 Provision of comprehensive End of Life/Palliative Care pathways across the city is important to ensure that structures are in place to facilitate end of life and palliative care patients having their clinical needs met at home or in the community, without having to be inappropriately transferred to the Acute Trust for ongoing management when this is not necessary.

11.2.2 The intention is that patients will be managed in the community and only transferred to acute care when their clinical condition mandates this. Implementing this structure and then supporting pathways of care will be a significant improvement for end of life experience for both patients and family.

11.2.3 A city-wide group (Mortality Improvement Group) with representation from RWT, CCG and Primary Care and Public Health has been set up to oversee and review mortality related issues and statistics across the health economy.

11.3 Engagement with Bereaved Families and Carers

11.3.1 The National Quality Board recently published guidance for NHS trusts on working with bereaved families and carers, recognising the importance of engaging with families and how to learn when things go wrong. The guidance advises trusts on how they should support, communicate and engage with families following the death of patients in their care.

11.3.2 The intention is to appoint a Bereavement Nurse to work alongside the Medical Examiner to improve overall support and experience for families. This role will be pivotal in ensuring that families and relatives are supported in the aftercare of their bereaved loved ones.
11.3.3 Evidence suggests that early and prompt interventions for high-risk individuals can facilitate grief coping strategies and can minimise the adverse consequences of grief. The bereavement nurse will be skilled in providing care to bereaved individuals and competent in providing compassionate and sensitive care with and alongside the support of the wider multi-disciplinary team.

11.4 Review of Deaths Post Hospital Discharge

11.4.1 At present the mortality reviews are limited to hospital deaths. However, around twenty-four percent of all deaths accounted for in the mortality statistics (SHMI) occur within thirty days of discharge from hospital.

11.4.2 Currently there is no established process of learning about the care provided or gaps in service for those who die outside of hospital. Discussion are underway with the CCG to agree the methodology and funding for reviewing care provision in community and primary care for out-of-hospital deaths. The expectation is that by reviewing these cases jointly, the health system across Wolverhampton will benefit from shared learning with the potential that a rich body of information will become available to inform themes, identify service gaps and areas for development.

11.5 Dedicated Mortality (SJR) Reviewers

11.5.1 One of the key challenges is timely completion of mortality reviews. The intention is to have a dedicated group of trained reviewers who can undertake SJRs, mortality reviews for SHMI alerting diagnosis and RCA's involving deaths. The time requirement for reviews will be resourced.

11.5.2 The new review process will be independent and help to reduce the workload for directorates who can concentrate on learning from reviews and investigations, and implement service changes.

11.6 Accurate Recording of Administration Data

11.6.1 Administrative data used in the mortality calculations does not accurately reflect the profile of patients admitted to the Trust, resulting in an elevated SHMI from a lower than expected mortality rate.

11.6.2 Acute medical clerking proforma was modified to enable capture primary diagnosis and co-morbidities during the admission episode. The Head of Clinical Coding is providing educational updates across all the clinical directorates, with a focus on the medical directorates, to ensure clinical documentation is as complete as possible, to enable primary and secondary diagnosis to be captured accurately, along with all relevant co-morbidities.

11.6.3 Recently undertaken clinical audits highlighted issues with documentation and recording of primary diagnosis for SHMI alerting diagnosis groups. Further education is being planned along with an initiative to facilitate
closer working between physicians and coders, initially on the Acute Medical Unit (AMU).

12 Clinical Quality Monitoring

12.1 The systems for monitoring quality need further focus to ensure we are maximising opportunities for analysis and learning. There are a number of portals for information currently but there is no one central location. A range of key performance and quality metrics are collated on a monthly basis and reported through the various governance structures within the organisation.

12.2 The Trust’s Governance Department generates a monthly information pack for Directorates and Divisions. The Directorate teams are required to use this information to report and provide assurance to their quarterly Divisional performance meetings. A monthly inpatient ward dashboard is in place and based primarily on a broad range of metrics, with the addition of appraisal and mandatory training. The intention is to create a ward dashboard of agreed Nurse Sensitive Indicators and the QRV and NAAS profiles to provide, a holistic picture, across the indicators and over time.

12.3 The process of sharing and learning from outcomes following all external reviews and national surveys, which includes quality assurance visits, patient and staff surveys and ‘Getting It Right First Time’ (GIRFT) reports, has been adapted in 2017/18. This information is cascaded across all levels of the organisation highlighting areas of good practice and where there is a need for improvement. The Trust’s Clinical Oversight Group and Quality Safety Improvement Groups seek assurance from the Divisions on improvement actions identified.

13 Mortality Action plan

13.1 An action plan supporting quality improvement will be monitored to ensure that the organisation is learning from mortality, which will impact positively on the quality of care and treatment delivered to patients.

14 Communication of Strategy

Key stakeholders within the mortality review group shall ensure the communication of this strategy to wider audiences and report upwardly to the Trust Board. Progress on communication shall be monitored through the mortality strategy group action plan.

15 Evaluation and Review*

The strategy will be reviewed yearly. However the strategic plan is a dynamic document which will be reviewed monthly by the Quality Improvement Group-Mortality for compliance against actions and progress of benefits realisation.

16 Equality statement*

An assessment has been undertaken, no adverse effects have been identified for staff, patients or the public.
17 Resource assessment

1. Does the implementation of this strategy require any additional Capital resources? No
2. Does the implementation of this strategy require additional revenue resources? No
3. Does the implementation of this strategy require additional manpower? No
4. Does the implementation of this strategy release any manpower costs through a change in practice? No
5. Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff? No

Other comments

18 RWT Mortality Action Plan (as of November 2018)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Expected Output/Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1 Programme Management (PM)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Develop a Trust Mortality Strategy</td>
<td>Strategy developed via consultation</td>
</tr>
<tr>
<td>2.</td>
<td>Agree TOR of MIG to include scope and development/Review</td>
<td>MIG terms of reference</td>
</tr>
<tr>
<td>3.</td>
<td>Terms of Reference for Mortality Review Group following merger of MoRAG</td>
<td>MRG TOR developed</td>
</tr>
<tr>
<td>4.</td>
<td>Programme Board and Action Plan to be developed</td>
<td>Programme Board established, Action plan</td>
</tr>
<tr>
<td>5.</td>
<td>Dashboard to be developed for monitoring of impact of actions</td>
<td>Dashboard presented to MRG</td>
</tr>
<tr>
<td>6.</td>
<td>Board Assurance Framework submission</td>
<td>Risk added to BAF</td>
</tr>
<tr>
<td>7.</td>
<td>Appoint external analytic expertise</td>
<td>Contract commenced</td>
</tr>
<tr>
<td>8.</td>
<td>Appoint external medical expert</td>
<td>Contract commenced</td>
</tr>
<tr>
<td>9.</td>
<td>Review mortality quality improvement plan monthly at programme board</td>
<td>Trust Board monthly update against action plan</td>
</tr>
<tr>
<td><strong>A2 City wide programme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Draw together current interested groups to work to one strategy (Acute, Comm, PH, Compton)</td>
<td>MIG meeting established, with action plan</td>
</tr>
<tr>
<td>2.</td>
<td>Pathways of EoL Care in and out of hospital reviewed</td>
<td>Redesign/agreement of pathways. Number of patients who die outside hospital</td>
</tr>
<tr>
<td>3.</td>
<td>In reach to care/nursing homes by C/E team</td>
<td>Reduction in admissions from Nursing Homes</td>
</tr>
<tr>
<td>4.</td>
<td>City wide EoL Strategy developed with milestones</td>
<td>City wide strategy</td>
</tr>
<tr>
<td>5.</td>
<td>Transformation Programme of Community Care</td>
<td>Transformation Action Plan</td>
</tr>
<tr>
<td>6.</td>
<td>Scope Nursing Home admissions</td>
<td>Review data and consider new care pathways. Data sent to CCG</td>
</tr>
<tr>
<td>7.</td>
<td>Scope EoL activity</td>
<td>2 projects. RWT to review activity, Public Health team to link data across Healthcare system</td>
</tr>
<tr>
<td><strong>A3 Policy/Processes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Establish a pathway for death certification linked to mortality reviews</td>
<td>Implement Medical Examiner model to integrate with SIR process</td>
</tr>
<tr>
<td>2.</td>
<td>Monitor compliance with OP97 (Learning from Deaths) SIR 1 &amp; 2</td>
<td>Completion of SIR 1 &amp; 2 reviews as per agreed standard</td>
</tr>
<tr>
<td>3.</td>
<td>Establish primary care mortality reviews for deaths within 30 days after hospital discharge</td>
<td>RWT, primary care and CCG to establish process and secure funding to undertake reviews</td>
</tr>
<tr>
<td>4.</td>
<td>To establish the process for including families/relatives in the SIR2 reviews</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Monitor results of SIR 2s and compile learning outcomes</td>
<td>Directorate present learning outcomes after SIR reviews at the Mortality Review Group.</td>
</tr>
<tr>
<td>6.</td>
<td>Expansion of the numbers of trained nurses/AHPs to support completion of SIR 1 and 2</td>
<td>Recruitment of nurses to undertake SIRs</td>
</tr>
<tr>
<td>7.</td>
<td>Triangulate outcomes of SIR’s with lessons learned from clinical audits, mortality reviews and coroners’ reports</td>
<td>Clinical audit programme reflects learning outcomes</td>
</tr>
<tr>
<td>8.</td>
<td>Learning from SIR 2s to be shared with Divisions, Trust Board and CCG</td>
<td>Lessons shared</td>
</tr>
<tr>
<td>9.</td>
<td>Coding reflects full diagnosis of population of admitted patients</td>
<td>Feedback on additional software</td>
</tr>
<tr>
<td>10.</td>
<td>Review analytical data provided by external experts to inform Directorates/Division/Coding and Executive teams</td>
<td>Feedback of coding and HED data monthly</td>
</tr>
<tr>
<td>Objective</td>
<td>Activity</td>
<td>Expected Output/Outcome</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>A4 Quality/Safety of Care Mortality Reviews</td>
<td>1. Review of medical documentation, coding and analytics</td>
<td>Feedback to RWT Governance structures</td>
</tr>
<tr>
<td></td>
<td>2. Reduce number of short term FCEs at ‘front door’</td>
<td>Appropriate reduction of FCEs</td>
</tr>
<tr>
<td></td>
<td>3. Alerts returned within two months Report presented and discussed at MRG within agreed timescales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Alerts returned within two months Report presented and discussed at MRG within agreed timescales</td>
<td></td>
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<td></td>
<td>5. Implement care pathway audit against best practice standards as CQI in all directorates</td>
<td></td>
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<tr>
<td></td>
<td>6. Directorates to agree and complete CQI audits</td>
<td></td>
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<tr>
<td></td>
<td>7. Monitor complaints, incident trends at Directorate, Divisional and Trust level via IQPR and TMC / Trust Board</td>
<td></td>
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<tr>
<td></td>
<td>8. Action Plan agreed</td>
<td></td>
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<tr>
<td></td>
<td>9. Quarterly review of rollout plan to COG</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. To all Governance meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Monitor compliance of VTE, sepsis, IP incidents, falls, pressure injuries via Directorate/Division/Trust</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Evidenced in meeting minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Nursing mortality audits commencing with sepsis and pneumonia pathways</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Completion and dissemination of audit results</td>
<td></td>
</tr>
<tr>
<td>A5 Education</td>
<td>1. Educational Package for coding to be developed for Medical teams</td>
<td>Educational Package developed and delivered</td>
</tr>
<tr>
<td></td>
<td>2. Educational Package for coding to be developed for Medical teams</td>
<td>Reduction in number of patients ‘R’ coded at 1st/2nd FCE (need to stipulate a %)</td>
</tr>
<tr>
<td></td>
<td>3. Educational Package for coding to be developed for Medical teams</td>
<td>Educational Package developed and delivered</td>
</tr>
<tr>
<td></td>
<td>4. Educational Package developed and delivered</td>
<td></td>
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<tr>
<td></td>
<td>5. Monitor and disseminate learning of SUIs through MRG</td>
<td></td>
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<tr>
<td></td>
<td>6. Evidence of improvements in care across pathways at Quarterly Directorate/Divisional reviews</td>
<td></td>
</tr>
<tr>
<td>A6 Workforce</td>
<td>1. Implement Medical Examiner model</td>
<td>ME recruitment and training 5 day ME rota (recruit and commence)</td>
</tr>
<tr>
<td></td>
<td>2. Safe nurse staffing levels at ward and team level</td>
<td>Staffing reviews bi-annually by Board providing transparent reporting</td>
</tr>
<tr>
<td></td>
<td>3. Monitor vacancy rates and implement Trust recruitment strategy</td>
<td>Report progress on monthly basis to Governance structure as per the NSF plan</td>
</tr>
<tr>
<td></td>
<td>4. Ensure safe medical staffing levels and adherence to 7 day standards</td>
<td>All patients seen daily by a consultant within 14 hours of admission and daily as standard</td>
</tr>
<tr>
<td></td>
<td>5. Further expand deteriorating patient ‘out reach team’</td>
<td>Business case 10th October recruitment Nov - Jan expansion of service Feb 2019</td>
</tr>
<tr>
<td></td>
<td>6. Recruit senior nurses to sepsis programme</td>
<td>Nurses commence Jan 2019 and improvement programme devised with measurable actions December 2018</td>
</tr>
<tr>
<td></td>
<td>7. Palliative Care team business case and implementation plan</td>
<td>Business case 20th October recruitment Nov - Jan expansion of service Feb 2019</td>
</tr>
<tr>
<td></td>
<td>8. Reduce vacancy and medical agency spend</td>
<td>Reduction in medical agency spend (by how much?)</td>
</tr>
<tr>
<td>A7 Communication Plan</td>
<td>1. Trust Board mortality briefings monthly</td>
<td>Minutes of Trust Board</td>
</tr>
<tr>
<td></td>
<td>2. Senior Managers’ Briefing</td>
<td>Update of actions monthly</td>
</tr>
<tr>
<td></td>
<td>3. Trust Newsletter</td>
<td>Quarterly Newsletter update</td>
</tr>
</tbody>
</table>
19  References

1. Professor Sir Bruce Keogh (July 2013), Review into the quality of care and
treatment provided by 14 hospital trusts in England

hospital deaths and association with hospital-wide mortality ratios: retrospective
case record review and regression analysis. BMJ 2015; 351:h3239

https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-
programme

4. Care Quality Commission (December 2016), Learning, candour and
accountability: a review of the way NHS trusts review and investigate the
deaths of patients in England

NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating
and Learning from Deaths in Care. National Quality Board.

Government, October 2018

7. The National Mortality Case Record Review (NMCRR) Programme (2016),
Royal College of Physicians (RCP).

20  RWT NHS Trust Associated Documents:

1. Trust Quality Account 2017/18
2. The Royal Wolverhampton NHS Trust Medical Certificate and Learning for
Deaths Policy
Background to Mortality Data and Trends at RWT

1. Standardised Mortality Ratio (SMR)

The SMR ratio is the ratio of observed deaths to expected deaths. In England SHMI (Summary Hospital-level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio) are used to measure standardised mortality ratio; but these approaches have some key differences. SHMI replaced HSMR as a national statistic in England and is reported quarterly by NHS Digital.

The SHMI ratio reports deaths during admission and up to 30 days following discharge, whereas HSMR only includes deaths in hospital and deaths in another hospital post discharge. SHMI also covers a wider range of admitted patients compared to HSMR. SHMI adjusts ‘expected deaths’ to account for the following patient characteristics: age, gender, method of hospitalisation (emergency or planned), primary diagnosis and associated conditions. HSMR adjusts for a few other variables, including palliative care coding in hospital records, month of admission, deprivation and the number of previous admissions.

The challenge with hospital mortality statistics is around how expected mortality is determined.

2. Standardised Hospital-level Mortality Indicator (SHMI)

SHMI indicator reported in England for RWT was 1.22 and classed as higher than expected for April 2017 to March 2018 (Figure 1). RWT is one of 35 acute trusts with higher than expected SHMI (98.8 CI) and the second highest in England.

Figure 1 - SHMI funnel plot England (April 2017 to March 2018):

![SHMI funnel plot](image)

Regionally, 8 trusts have higher than expected SHMI (Figure 2).
3. SHMI Trend (RWT)

The SHMI for RWT has increased from quarter 3 of 2015/16. This increase coincided with the opening in November 2015 of the new Urgent and Emergency Care Centre (Figure 3). The opening of the new ED (Nov 2015) alongside changes in pathways including the adoption of a Physician A model led to an overall reduction in medical admissions (Figure 4). The reduction of medical admissions continues to be sustained.

Figure 3 - RWT SHMI trend:
4. Expected Mortality Rate and Discharges

Expected mortality is the estimated number of deaths that would be expected based on average England figures, taking into consideration patient characteristics including age, sex, and method of admission, current and underlying medical conditions. The severity of illness at the time of admission is not taken into consideration.

There are several reasons why hospitals may have an elevated mortality ratio other than care quality, including:

- Changes in the profile of patients admitted;
- Local deprivation profile;
- Un-modelled risk factors in the population (e.g. smoking, alcohol etc);
- End of Life infrastructure and care for the dying in the community;
- Admission pathways;
- Severity of illness of those admitted;
- Proportion of people dying in hospital rather than in their own home, nursing home or hospice;
- Coding practices in the hospital around cause of admission and associated conditions

The most obvious reason for the higher SHMI for RWT is the decreasing calculated expected mortality for the Trust in contrast with the increasing expected mortality nationally, see Figures 5 and 6.
The changes in SHMI data for RWT and England is most pronounced for emergency admissions.

### TABLE 1 Change in Emergency Admissions Profile

<table>
<thead>
<tr>
<th>Changes observed in SHMI data</th>
<th>RWT</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed mortality</td>
<td>Expected Mortality</td>
</tr>
<tr>
<td>Apr15-Mar16 vs Apr14-Mar15</td>
<td>3.94%</td>
<td>5.42%</td>
</tr>
<tr>
<td>Apr16-Mar17 vs Apr15-Mar16</td>
<td>-0.46%</td>
<td>-4.66%</td>
</tr>
<tr>
<td>Apr17-Mar18 vs Apr16-Mar17</td>
<td>-2.42%</td>
<td>-3.76%</td>
</tr>
</tbody>
</table>

Reductions in calculated expected mortality rate suggests RWT admits a higher proportion of patients with a low expected mortality than the national picture. The clinical opinion is that the admission avoidance model in ED resulted in a reduction in medical admissions of patients with ‘less severe’ illness. On this basis, an increase in the expected death rate would be expected given the likelihood of admitting a higher proportion of medical patients who are sicker and frail with co-morbidities, suggesting that the expected death rate calculation is not adequately adjusting for our patient profiles.
5. Crude Mortality Rate

Crude mortality is the number of deaths expressed as a percentage of admissions. An increase in admissions of patients from the cohorts with the most severe disease will affect the crude mortality.

There have been changes in the crude mortality rates in RWT. An increase in the number of deaths was noted in Qtr4 2017/18. The crude mortality rate was higher in both Qtr3 & Qtr4 2017/18. More deaths were observed in the older age group (>80 years) when compared with previous years in the context of reduced number of admissions proportionally for this age group.

![Figure 7 - RWT deaths and Crude Mortality Rate](image)

6. City-wide Office of National Statistics (ONS) Mortality Data

Data on deaths across the city is based on information recorded in death certificates, which eventually is reported by the Office for National Statistics within ONS Mortality Statistics. This data is a more reliable compared to hospital mortality data.

Compared to similar Local Authorities (based on deprivation), Wolverhampton has a similar overall death rate (adjusted for age). There has been some increase in deaths from circulatory diseases (such as heart disease and stroke) in recent years. Circulatory diseases, cancers and respiratory diseases are the top 3 causes of death in Wolverhampton and share common risk factors (e.g. smoking and obesity).

When compared to the West Midlands and the rest of England, Wolverhampton has high overall death rates, specifically for deaths related to alcohol, which has been a persistent theme for the City for many years.
7. Place of Death

Place of death has a significant bearing on mortality statistics and can contribute to an elevated SHMI based on availability of EOL care locally and provision of community care closer to home.

The SHMI indicator includes deaths occurring in hospital and within 30 days after discharge. The Trust has one of the highest proportions of in hospital deaths compared to those that die in the community, in the country and the highest in the region; this has been constant at least for the last 3-4 years, as depicted in figure 9.

Figure 9 - Percentage SHMI deaths occurring in hospital (HED data):

Data from Public Health also supports this observation. Wolverhampton Health Economy has a higher in-hospital deaths percentage compared with the English mean (Figure 10). Specifically, Wolverhampton is an outlier for hospital deaths in people aged 0-64 years and over 85 years. Hospice deaths are significantly lower in people aged 0-64 years.
8. Clinical Coding

Accurate recording of primary diagnosis, secondary diagnoses and co-morbidities for all admissions is important as they impact on the calculated expected mortality rate and alerting diagnosis. Clinical audits undertaken for SHMI alerting diagnosis groups have clearly identified issues with recording of primary diagnosis.

The depth of coding at RWT is better in comparison to other neighbouring Trusts (Fig 11). However, the average co-morbidity score can be misleading as only data recorded during the first episode of care, also called first finished consultant episode (FCE), impacts on the expected mortality rate. Figure 12 compares the co-morbidity score recorded during the 1st episode of care for admissions in the SHMI dataset. Dementia, congestive heart failure (CHF) and metastatic carcinoma have the highest scores when recorded as comorbidity. For metastatic carcinoma, RWT’s scores are higher compared to England, but there hasn’t been any increase. For dementia and CHF, the scores are lower than England’s average and there has not been an increase either; a drop is seen in 2016-17.

This is contrary to the observations following implementation of the admission avoidance model in ED. Hence, the likely explanation is that administrative data in the first episode do not reflect accurately the characteristics of admitted patients.
RWT had a higher number of FCEs per hospital spell. This had an impact on accurate capture of primary diagnosis and co-morbidities during the first FCEs as they were inevitably shorter in duration. Limiting the number of FCEs per spell is important as it enables coders to extract the required clinical information more appropriately for an episode of care.

The internal process was modified, such that the initial FCE was for the duration of stay on the Acute Medical Unit, and the second FCE was following transfer to the specialty ward. Figure 13 demonstrates the reduction in FCE’s per spell from April 2018 and this should improve data capture by coders.
Figure 13 - FCE’s/spell:

Average no. of FCE’s per Spell - Non elective Admissions excluding zero LoS
April 2011 - July 2018
Implementation Plan template for Strategy / Policy / procedural documents

To be completed showing all actions needed to implement the Strategy/policy/Procedural document. If a more detailed action plan exists eg for a strategy, this can be referred to here or include key headline extracts. This implementation plan (Attachment 8) must be completed and submitted with the policy for consideration / approval.

<table>
<thead>
<tr>
<th>Title of document:</th>
<th>Mortality Strategy 2019-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date approved:</td>
<td></td>
</tr>
</tbody>
</table>

Is the Strategy/Policy/Procedural document new or existing?

<table>
<thead>
<tr>
<th></th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation lead name and contact details if different from the author.</td>
<td>Jake Botfield x704957</td>
</tr>
</tbody>
</table>

1. If new you have created a new implementation plan?
2. If existing you have reviewed/added to the last implementation plan?

<table>
<thead>
<tr>
<th>Implementation Issue</th>
<th>Action Summary</th>
<th>Action lead/s (Timescale for completion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Strategies; Consider</td>
<td>1. Draw together current interested groups to work to one strategy (Acute, Comm, PH, Compton) MIG meeting established, with action plan</td>
<td>1. ongoing</td>
</tr>
<tr>
<td></td>
<td>2. Pathways of EoL Care in and out of hospital reviewed. Redesign/agreement of pathways. Number of patients who die outside hospital</td>
<td>2. 28/02/2019</td>
</tr>
<tr>
<td></td>
<td>3. In reach to care/nursing homes by C/E team / Scope Nursing Home admissions Review data and consider new care pathways for planned reduction in admissions from Nursing Homes. Data sent to CCG.</td>
<td>3. 31/12/2018</td>
</tr>
<tr>
<td></td>
<td>4. City wide EoL Strategy developed with milestones. Monitor GSF roll out for inpatient and community populations. City wide strategy. Quarterly review of rollout plan to COG.</td>
<td>4. ongoing</td>
</tr>
<tr>
<td></td>
<td>5. Transformation Programme of Community Care Transformation Action Plan</td>
<td>5. 30/03/2019</td>
</tr>
<tr>
<td></td>
<td>6. Scope EoL activity 2 projects. RWT to review activity, Public Health team to link data across Healthcare system</td>
<td>6. 31/03/2019</td>
</tr>
</tbody>
</table>
## Training; Consider

1. Mandatory training approval process
2. Communication of training programmes to targeted staff or development of e-training on kite

<table>
<thead>
<tr>
<th>Educational Package for coding to be developed for Medical teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Package developed and delivered</td>
</tr>
<tr>
<td>Reduction in number of patients 'R' coded at 1st/2nd FCE (need to stipulate a %)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Package for SJRs to be developed for Medical and Nursing teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Package developed and delivered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitor and disseminate learning of SUIs through Governance structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of improvements in care across pathways at quarterly Directorate/Divisional reviews</td>
</tr>
</tbody>
</table>

### Development of Forms, leaflets etc

1. Trust Board mortality briefings monthly
2. Senior Managers' Briefing
3. Trust Newsletter

| As above |

### Strategy / Policy / Procedure communication;

| N/A |

### Financial cost/Procurement implications

| N/A |

### Other specific Policy issues / actions as required e.g. Identify risks surrounding failure to implement, anticipated gaps or barriers to implementation.

| N/A |