The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	24 June 2013
Title:	Mortality
Executive Summary:	The RWT HSMR for 2011/12 was 100.4. The RWT HSMR for April 2012 - March 2013 is 98.5 (re-based 103.5), both within expected limits. The observed death rate is 3.8% (2012/13) and the expected death rate is 3.9% (for 2012/13), suggesting potential loss of depth of coding (and hence a loss of risk reduction) for in-patients. Actions are being implemented across the organisation to address (and correct) this possibility. One internal alert (Pneumonia) and one Dr Foster alert (Other Psychoses) were investigated by case note review late May 13 and the reports will be concluded week ending 21st June 13. Further analysis of one outlying diagnosis group (senility and other organic mental disorders) is in process of being carried out. All alerts for all diagnosis and procedure groups for 2012-13 are being investigated and reports will be presented shortly (Coma, stupor and brain damage, external resuscitation, high cost drugs, rest of heart). Lower threshold alerts are also being proactively investigated.
Action Requested:	Report for information and reassurance
Report of:	Medical Director
Author: **Contact Details:**	Medical Director Tel 01902 695958 Email: Jonathan.Odum@nhs.net
Resource Implications:	Nil

Public or Private: (with reasons if private)	Public Session
References: (eg from/to other committees)	
Appendices/ References/ Background Reading	
NHS Constitution: (How it impacts on any decision-making)	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

BACKGROUND DETAILS

Royal Wolverhampton Trust – HSMR

The RWT rebased HSMR for 2011/12 was 100.4 with an observed death rate of 3.62% and an expected death rate of 3.60% (Table 1).

Table 1: HSMR April 2011-March 2012

Peer (WM Acute)	Spells	Deaths	%	Expected	%	RR	Low	High
George Eliot Hospital NHS Trust	11046	707	6.5%	591.8	5.4%	119.5	110.8	128.6
Walsall Healthcare NHS Trust	19991	1041	5.2%	893.4	4.5%	116.5	109.6	123.8
University Hospitals Birmingham NHS FT	32616	1434	4.5%	1276.7	4.0%	112.3	106.6	118.3
Burton Hospitals NHS FT	21683	840	4.0%	748.7	3.5%	112.2	104.7	120
The Dudley Group NHS Foundation Trust	33529	1420	4.3%	1278.1	3.8%	111.1	105.4	117
Wye Valley NHS Trust	12049	645	5.4%	588.5	5.0%	109.6	101.3	118.4
Worcestershire Acute Hospitals NHS T	39812	1795	4.5%	1681.1	4.3%	106.8	101.9	111.8
University Hosp Of North Staffs NHS T	49838	1944	3.9%	1878	3.8%	103.5	99	108.2
University Hospitals Coventry and Warwickshire NHS Trust	43877	1575	3.6%	1532.7	3.5%	102.8	97.7	108
The Royal Wolverhampton NHS Trust	37375	1315	3.6%	1309.5	3.6%	100.4	95.1	106
Shrewsbury and Telford Hospital NHS T	42100	1482	3.5%	1486.8	3.6%	99.7	94.7	104.9
Sandwell & West Birmingham Hospitals NHS T	39514	1534	3.9%	1546.9	3.9%	99.2	94.3	104.3
Heart Of England NHS Foundation Trust	69663	2822	4.1%	2875.3	4.1%	98.1	94.6	101.8

The HSMR for financial year April 2012 – March 2013 is 98.5, within expected limits (rebased 103.5) (Table 2).

Table 2: HSMR current and rebased prediction, April 2012-March 2013

Peer (WM Acute)	Spells	Deaths	%	Expected	%	RR	Low	High	Rebased RR
George Eliot Hospital NHS T	10853	740	6.9%	639.5	6.0%	115.7	108	124.4	120.7
Burton Hospitals NHS FT	21053	925	4.5%	854.8	4.2%	108.2	101	115.4	113.2
University Hospitals Birmingham NHS FT	35110	1518	4.4%	1421	4.1%	106.8	102	112.3	111.8
Wye Valley NHS Trust	11617	624	5.5%	585.4	5.1%	106.6	98.4	115.3	111.6
Heart Of England NHS FT	71429	2894	4.1%	2849.8	4.0%	101.5	97.9	105.3	106.5
The Royal Wolverhampton NHS Trust	37833	1416	3.8%	1437.8	3.9%	98.5	93.4	103.7	103.5
Worcestershire Acute Hospitals NHS Trust	42204	1796	4.3%	1831.1	4.4%	98.1	93.6	102.7	103.1
The Dudley Group NHS FT	34224	1451	4.3%	1509.1	4.4%	96.2	91.3	101.2	101.2
University Hospitals Coventry and Warwickshire NHS Trust	45247	1592	3.6%	1706.6	3.8%	93.3	88.8	98	98.3
University Hospital Of North Staffordshire NHS Trust	53494	2188	4.1%	2353.1	4.5%	93	89.1	97	98
Shrewsbury and Telford Hospital NHS Trust	41895	1542	3.7%	1681.7	4.0%	91.7	87.2	96.4	96.7
Walsall Healthcare NHS T	20922	973	4.7%	1089.9	5.2%	89.3	83.7	95.1	94.3
Sandwell and West Birmingham Hospitals NHS T	39448	1430	3.6%	1608.5	4.1%	88.9	84.4	93.6	93.9

The RWT SHMI

For the 12 month rolling period October ’11- September ’12 the SHMI is 101 (Dr Foster data).
For the 12 month rolling period December ’11- November ’12 the SHMI is 101.01 (HED data).

The charts below show the SHMI trends by quarter (Chart 1) and by rolling 12 months period (Chart 2) using 95% confidence intervals. A sustained improvement is noted from 2011-12 onwards, with the latest quarter very close to being significantly better than expected (upper CI = 100.53).

Chart 1: SHMI quarterly trend (source Dr Foster Intelligence)

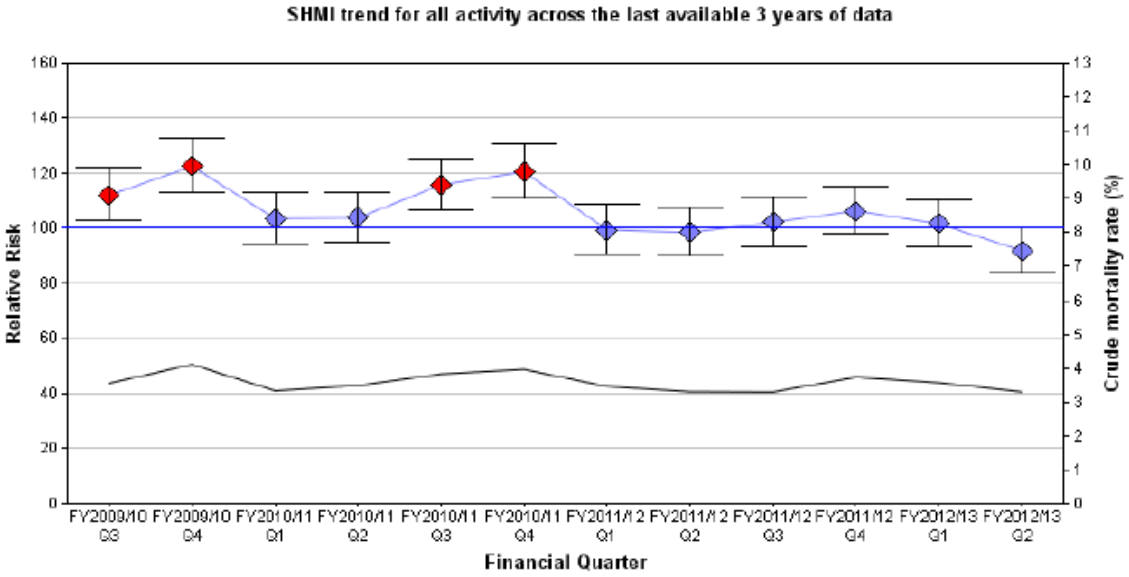
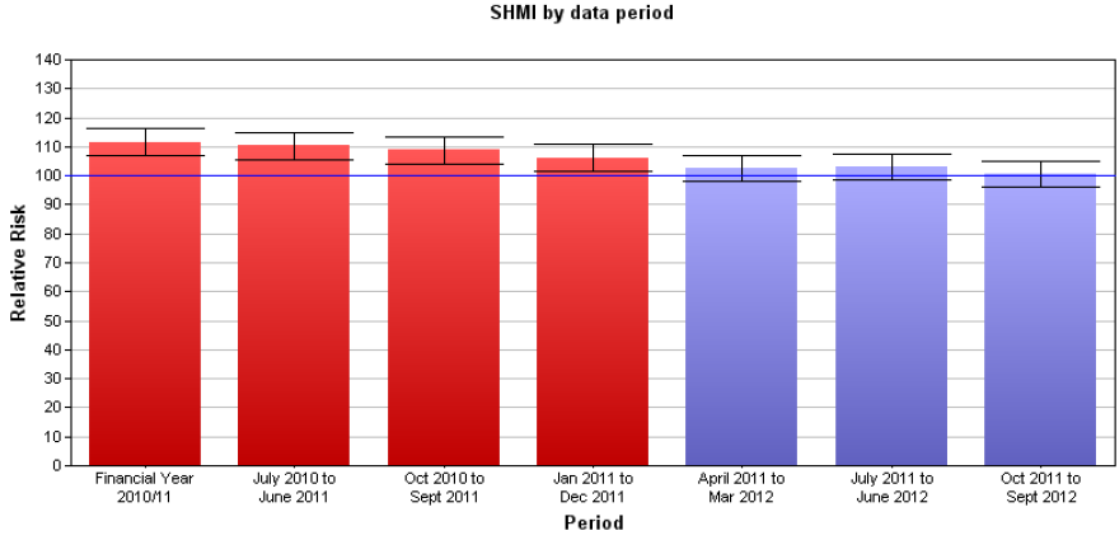


Chart 2: SHMI financial year trend (source Dr Foster Intelligence)



Clinical Coding and Relative Risk

The expected death rate of 3.9% for 2012-13 is the second lowest within the West Midlands Peer Group after Coventry and Warwickshire (3.8%) and 0.4% lower than the group's average expected crude death rate. Dudley and Walsall have higher expected death rates of 4.4% and 5.2% respectively.

Given that the demographics of the Wolverhampton population are similar to those of Dudley and Walsall, the above discrepancies in expected death rate suggest that the depth of coding of in-patients is potentially incomplete and therefore the relative risk of in-patients is underestimated.
The consequence of the above is that the HSMR will be "artificially" higher than it should be. Consequently, further work is required to ensure that coders are able to "capture" all the relevant and appropriate primary and secondary diagnoses, and co-morbidities to ensure that our coding is accurate. As the risk models use information on admission it is important to ensure that recording and coding of diagnoses and comorbidities on admission is accurate.

Actions put in place to help achieve this are as follows:

Work is ongoing with coding department and across the clinical directorates to ensure depth of coding is both recorded and captured from the clinical records.

We continue to benchmark nationally and against local peers and investigate proactively all diagnosis and procedure groups where outlying activity is noted.