

Trust Board Report

Meeting Date:	
Title:	July 2011 Mortality Summary
Executive Summary:	The report provides a summary of the year end HSMR mortality position and recent trends in the determinants of the indicator.
Action Requested:	To Note
Report of:	Cheryl Etches, Director of Nursing and Midwifery
Author: Contact Details:	Sultan Mahmud, Associate Director Tel 01902 695948 Email s.mahmud@nhs.uk
Resource Implications:	None identified
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)	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> ✚ 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

1	<p><u>HSMR-</u></p> <p>The HSMR is a method of comparing mortality levels in different years, and for different patient groups within the year, while taking account of differences in casemix. The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. HSMRs are based on the routinely collected administrative data often known as HES, SUS or CDS.</p>
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The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient based upon the casemix adjustments below.

Adjustment for case mix

Risks take into account those patient characteristics that are most strongly correlated with death and which reflect the patient's risk profile rather than the way in which the hospital has treated them. These factors are:

- Age
- Deprivation
- Sex
- Ethnicity
- Primary diagnoses grouped into CCS groups
- Method of Admission
- Month of Admission
- Source of Admission
- Whether or not palliative care (Z51.5 code)

Measuring hospital performance is complex. It is the advice of the DH that HSMRs and similar indicators should not be used in isolation, but rather considered with as part of a group of analytics

Mortality Dashboard- July 2011

Apr-March 2011

Source: Dr Foster

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn
HSMR	102.6	112.3	93.4	109.8	107.9	94.2	99.9	97.5	106.4	103.4	103.4	95	102
Observed Death Rate (56 CCS Groups)	3.80%	3.70%	3.20%	4.20%	3.80%	3.50%	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	4.08%
Expected Death Rate (56 CCS Groups)	3.70%	3.30%	3.40%	3.80%	3.50%	3.70%	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	3.98%
No of In Hospital Deaths	155	131	120	148	135	134	148	146	196	186	148	163	1810
Expected Deaths	135	122	130	145	133	141	150	154	186	183	151	164	1793
Excess Deaths	20	9	-10	3	3	-7	-2	-8	10	3	-3	-1	17

The year end un-rebased position shows a HSMR of 102 which is 2 points above the England average, there were 17 excess deaths according to the Dr Foster statistical calculation. The year end HSMR marks a marked improvement in the end of year position compared to 2008/9 [109] and 2009/10 [116].

Top Diagnostic Groups Contributing to Patient Deaths by Volume

Apr-March 2011

Source: Dr Foster

Diagnosis Group	Spells	Observed Deaths	Expected Deaths	Excess Deaths	SMR
Pneumonia	988	254	222	32	114
Acute Cerebrovascular disease	765	172	147	25	117
Congestive heart failure, nonhypertensive	502	92	75	17	123
Septicaemia (except in labour)	211	81	72	10	113

The top diagnostic groups contributing to in hospital deaths are set out above. There is a rolling programme of clinical case note review and detailed data interrogation, to glean systemic clinical process issues. Recent audits conducted have not revealed any systemic issues.

Alert Status

Cusum Statistical Mortality Alerts

Alert received April 2011 = 0

Alert received March 2011 = 0 2010-11 Cumulative= 12

Associated Indicators of Mortality

Indicator	Period	Target	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-Feb 10	Peer Group Average 5.76	5.35		⬆️
Palliative Care Deaths Per 1000 Spell (HED)	Apr-Feb 10	Peer Group Average 18	13		⬆️
Expected Death Rate (Dr F)	Apr10-Mar11	Peer Group Average [4.1%]	3.9%		⬆️

Apr-Feb 2011, HED ANALYTICS

The indicators here represent non-clinical coding related elements that contribute to the Trust's expected death rate. The Peer Group average is calculated from acute Trusts that have similar populations as set out by the Office of National Statistics. As a result of the targeted work conducted by the coding team improvements have been seen consecutively in January and February 2011, the programme of work is ongoing and further improvements can be expected in subsequent months.

Associated Clinical Process Indicators

Indicator	Jan-11	Feb-11	Mar-11	TREND
Number cardiac arrests	41	29	32	↓
% compliance observations completed	98.0	98.0	98.0	↔

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring that staff are trained to undertake these procedures and understand their clinical relevance

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