The Royal Wolverhampton
NHS Trust

Mortality Update Report
30 July 2018

Agenda Item No: 7.2

The Royal Wolverhampton NHS
NHS Trust

Trust Board Report

Meeting Date:	30th July 2018
Title:	Mortality Update Report
Executive Summary:	This report presents the Trust's most recent mortality statistics (January – December 2017) which confirms significant outlier status with the HSMI for the time period rising to 119 (compared with 118 for October 2016 – September 2017). The RWT expected death rate has risen slightly to 3.3%, and the crude death is slightly higher at 3.9%. Notably, the total number of discharges included in the SHMI has fallen further. Work continues to review the quality of care provided to and received by patients presenting to the Trust, using the Structured Judgment Review (SJR) process for review of case notes of deceased patients, and a programme of audit/QIP is being developed for those pathways of care for diagnostic groups with elevated SMR's. The Learning From Deaths policy (OP87) is embedded across Directorates and Divisions with monitoring of compliance at Directorate and Divisional level, with overview by the Mortality Review Group and Trust Committee structure. There are some challenges with completing the case note reviews due to numbers and time commitment, which are being managed (whereby resource is currently being identified to address) Work also continues to ensure that data capture for inpatient spells (elective and non-elective) is as complete and accurate as possible. The Trust is currently in the process of implementing the Medical Examiner role to further strengthen and enhance the scrutiny of deaths/mortality in the organisation with posts currently being out to advert. RWT has a high percentage of in-hospital deaths for the local health economy, compared with the national mean. End of life care, and pathways supporting palliation in the community and primary care are to be strengthened to enhance patient experience, and to ensure patient and family requests/expectations of "place of death" are respected and achieved.
Action Requested:	Receive and note
For the attention of the Board	To note the further rise in the SHMI, the slight rise in total deaths during the time period in question, and the reduction in ordinary admissions (discharges).
Assure	The Board has previously been reassured through data analysis that the increased SHMI is not an indicator of avoidable mortality or quality of care. However, work continues to review and, where possible, enhance quality of care provision across admission pathways with elevated SMR's. Work also continues to address coding & data capture with respect to accuracy and completeness prior to submission of data.

Advise	Raised SMR's can impact on a Trust's reputation. RWT's elevated SHMI is a focus of external scrutiny with assurance being requested and provided regarding the work undertaken, as described above and in this report. It has been agreed that the elevated SHMI should be placed on the Trust BAF
Alert	Diagnostic groups with elevated SMRs currently under review are as follows: Acute Cerebrovascular Accident Aspiration Pneumonitis Congestive Heart failure Pneumonia Acute Bronchitis Biliary Tract disease Skin and Subcutaneous infections Fluid & Electrolyte disorders Other Connective tissue disease Oesophageal disorders Chronic Ulcer of the Skin Other Endocrine disorders Chronic Renal failure
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Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 6. Be in the top 25% of all key performance indicators
Resource Implications:	Revenue: Capital: Workforce: Funding Source:
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Equality and Diversity Impact	N/A
Risks: BAF/ TRR	4734
Risk: Appetite	The elevated SHMI to be placed on the Trust's BAF.
Public or Private:	Public
Other formal bodies involved:	Mortality Review Group/Compliance Oversight Group/Quality Standards Improvement Group/Quality Governance Assurance Committee/Trust Management Committee
References	
NHS Constitution:	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

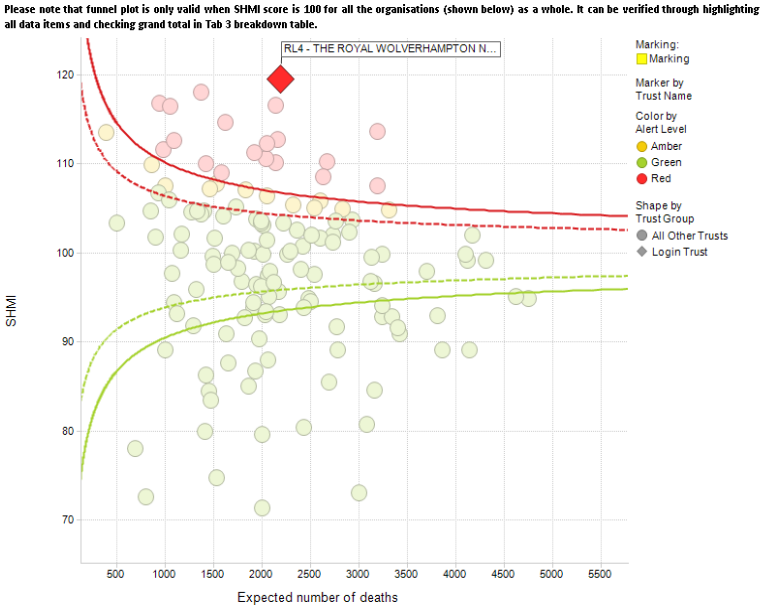
Report Details

1. **Standardised Mortality Rates**

The Summary Hospital-level Mortality Indicator (SHMI) reported for England for RWT (January – December 2017) was 1.19 and is higher than expected.

The funnel plot (Figure 1) presents the RWT position in relation to other Trusts in England.

Figure 1



The difference in trends when comparing RWT data with the England data continues to increase. Table 1 presents the RWT statistics and relates this to the data for England. As can be seen, there has been a slight increase in the RWT crude death percentage, and also a small increase in the expected death percentage, but a further significant fall in the number of RWT discharges included in the SHMI which has a further impact on the RWT expected death rate

Table 1

Reporting Period	SHMI RWT	RWT Crude Death %	RWT Expected Death %	England Crude death %	RWT No. discharges included in SHMI	RWT No. Deaths SHMI	RWT No. expected deaths SHMI	England No. discharges included in SHMI	England no. observed/ expected deaths
Apr14-Mar15	99	3.6%	3.6%	3.3%	66,813	2,372	2,394	8,732,830	286,629
Apr15-Mar16	106	3.6%	3.4%	3.2%	69,540	2,528	2,384	8,825,694	282,723
Apr16-Mar17	115	3.7%	3.2%	3.3%	69,524	2,572	2,235	8,908,215	293,623
Jul16-Jun17	116	3.7%	3.2%	3.3%	68,784	2,566	2,204	8,915,877	292,307
Oct16-Sep17	118	3.8%	3.2%	3.3%	68,636	2,599	2,194	8,933,241	292,595
Jan17-Dec17	119	3.9%	3.3%	3.3%	67,425	2,623	2,195	8,744,518	292,193

The expected mortality at RWT remains lower than in 2014/15 and is at the same as the national crude mortality rate, which for RWT which does not reflect the local population treated at the Trust with its high deprivation/co-morbidities.The RWT number of expected deaths, remains the same as the previous reporting time period (October 2016 – September 2017), but has progressively fallen since 2014/2015.

It should also be noted that the SHMI does not take into account acuity/severity of illness in its' calculation of the relative risk of death for individual cases.

The data presented confirms and extends the information provided in the April (and previous)Trust Board report, with a slight increase in the number of deaths and a decline in the number of ordinary discharges to its lowest from 2014/15.

Figure 2 shows the expected mortality trends (RWT and England), and as can be seen the expected mortality continues to decline at RWT and is significantly below the expected mortality position for England.

Figure 2

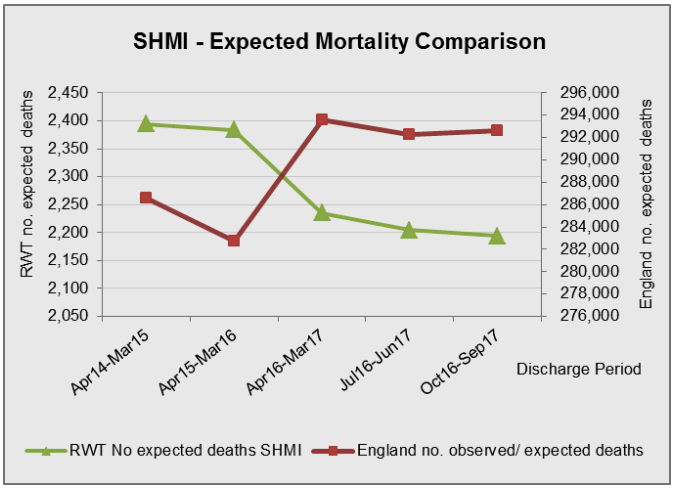
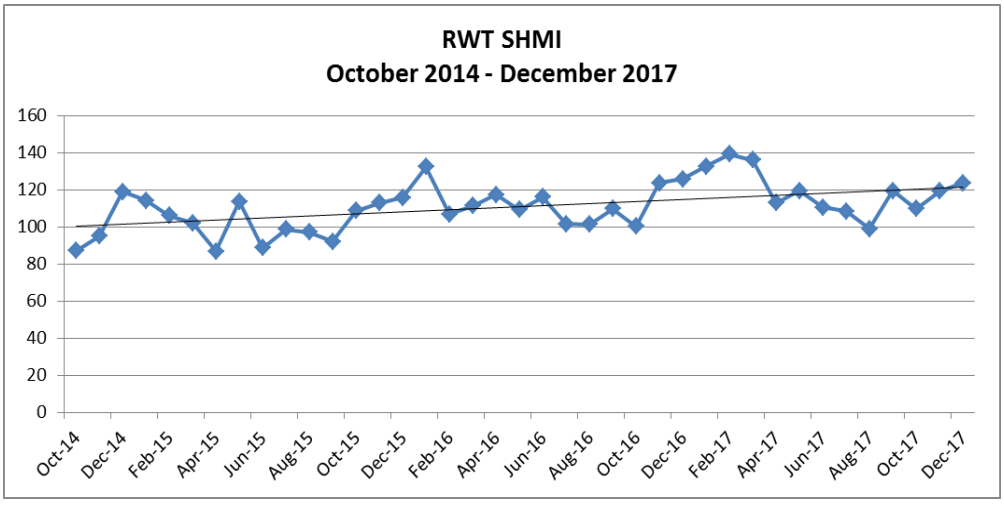


Figure 3 shows the increase in SHMI from 2014 through to 2017. The increase in SHMI has largely occurred from October 2015 onwards, commensurate with the opening of the new Urgent & Emergency Care Centre, with the new pathways of assessment and admission.

Figure 3



2.	**<u>Update on the National Guidance on Learning From Deaths</u>** Compliance with the Mortality Policy (OP87) continues to be monitored through the Mortality Review Group. The Structured Judgement Review (SJR) training has now been rolled out across RWT and, at present, all deaths undergo a case record review using SJR stage 1 process. As of July 2018, 70% of deaths have been reviewed. Cases identified as receiving poor/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. Cases triggering an SJR 2 are allocated within one month of trigger, and, at present, completion rate is 41%. Following completion of the SJR 2, cases are referred back to the Directorate for discussion at their MDT, and the learning from the deaths is then completed and actioned within the Directorates/Divisions. Deaths reviewed through the SJR Stage 2 process have an assessment of avoidability, as part of the review. Outcomes related to avoidability identified in cases noted via the Trusts mortality review group in July were: Communication regards End of Life pathway, Consent, MCA knowledge and implementation, Sepsis treatment initiation, overall contemporaneous documentation. Deaths undergoing the initial SJR Stage 1 process which identifies significant omissions in care, are directly escalated to Serious Incident status, and will undergo a formal RCA. All deaths undergoing formal RCA (irrespective of how they are identified) will have avoidability of death as one of the outcomes of the investigation process. The avoidable deaths index/number is presented in the IQPR, and avoidability is assessed is assessed at the time of completion of the RCA for a SUI, or at the SJR Stage 2 review. As note in the introduction, the time commitment to undertaking the SJR reviews is considerable and it is a challenge across the directorates and Trust to comply with the timescales set out in OP87. This issue is being actively managed and should be helped significantly by the introduction of the Medical Examiner role (see below).
3.	**<u>Medical Examiner Role</u>** The introduction of the Medical Examiner role across England has been “in development” for some years, and was initially a recommendation following the Shipman Enquiry, and more recently the Francis Enquiry. RWT is in the process of implementing the Medical Examiner role, and is currently out to advert, requesting applications from Consultants and other medical staff, registered for a minimum of 5 years to undertake the role. It is expected that a number of medical staff will be required to work as a team supporting this role, with the number of sessions of time required being between 12-16 PA’s (in total). Medical Examiners will work alongside the staff in the Bereavement Office, and will undertake an initial review of all deaths in the organisation. Any issues of concern will be formally escalated, with the opportunity to discuss deaths individually with the Coroner’s Office and/or escalate issues of care either to a SJR process directly or alternatively, for investigation through the Serious Incident process. Medical Examiners will review and confirm the entry to be made on the death certificate, and also provide an opportunity to liaise with families and address and explore any concerns with care that may be expressed. All deaths will be reviewed, including those that would be expected to be formally escalated to the SJR process, including deaths for patients with learning disability, mental health issues, elective/unexpected deaths, etc. This development will be a significant factor in improving the management of deaths for the organisation.

4. **Monitoring of Diagnostic Groups with Elevated SHMI/HSMR**

Those Diagnostic Groups (below) 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 or not a death may be potentially avoidable. These reviews are undertaken by specialists in the diseased category. A coding review of primary and secondary diagnoses is also undertaken.

The following Diagnostic Groups are currently subject to this process:

Pneumonia; Chronic Bronchitis, Acute Kidney Injury/ Fluid & Electrolyte Disorders; Cerebral Vascular Disease (Stroke); Sepsis.

Please note audits of compliance with the Sepsis pathways across the organisation have been undertaken, under the auspice of the Sepsis Leads and the Deteriorating Patient Group, as a separate exercise.

In addition, all the above Diagnostic Groups will have the admission pathways of care formally audited through the Clinical Excellence Group, with quality improvement programmes implemented, dependent upon the outcome of the audit. This will be an ongoing QIP across the pathways of care in the organisation.

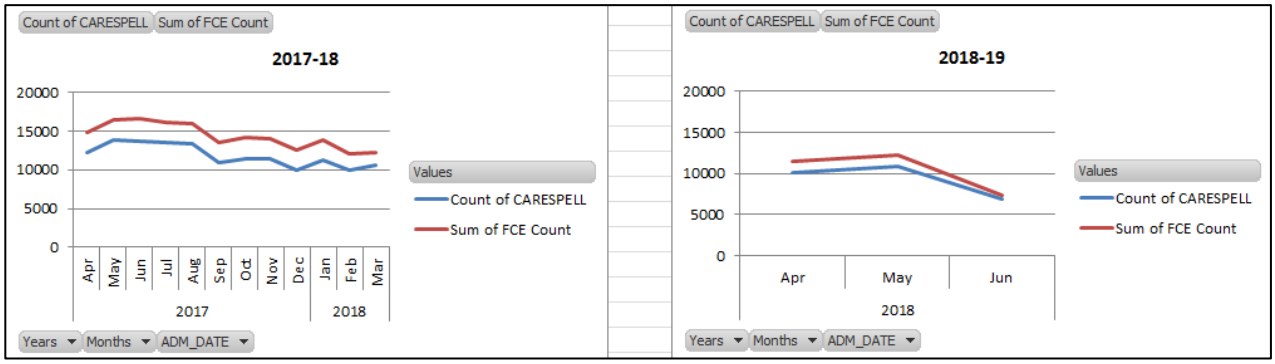
5. **Clinical Coding & Finished Consultant Episodes (FCE's)**

The Head of Clinical Coding is providing educational updates across all the clinical directorates, with a particular 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 (depth of coding).

With the new pathways of care introduced following the opening of the UECC in November 2015, Consultant designation of admitted medical patients has now been changed, such that the initial FCE will be for the duration of stay on the Acute Medical Unit, and the second Consultant attribution (second FCE) following transfer to the specialty Ward. This will appropriately limit the number of FCE's and enable Clinical Coders to extract the required clinical information more appropriately for submission of data centrally.

Figure 4 demonstrates the reduction in FCE's graphically, as of May 2018.

Figure 4



6. **Wolverhampton Mortality reduction Group and End of Life/Palliative Care Pathways**

A city wide group (Wolverhampton Mortality Reduction Group) has been set up to oversee and review mortality related issues and statistics across the health economy. This group is multidisciplinary and will be chaired by the CCG Chairman.

A significant agenda item is reviewing the End of Life/Palliative Care pathways across the city to ensure that a comprehensive structure is 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 patients will be managed in the community and only transferred up to RWT 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. At present, Wolverhampton Health Economy has a higher in-hospital deaths percentage compared with the English mean (Figures 5 & 6).

Figure 5

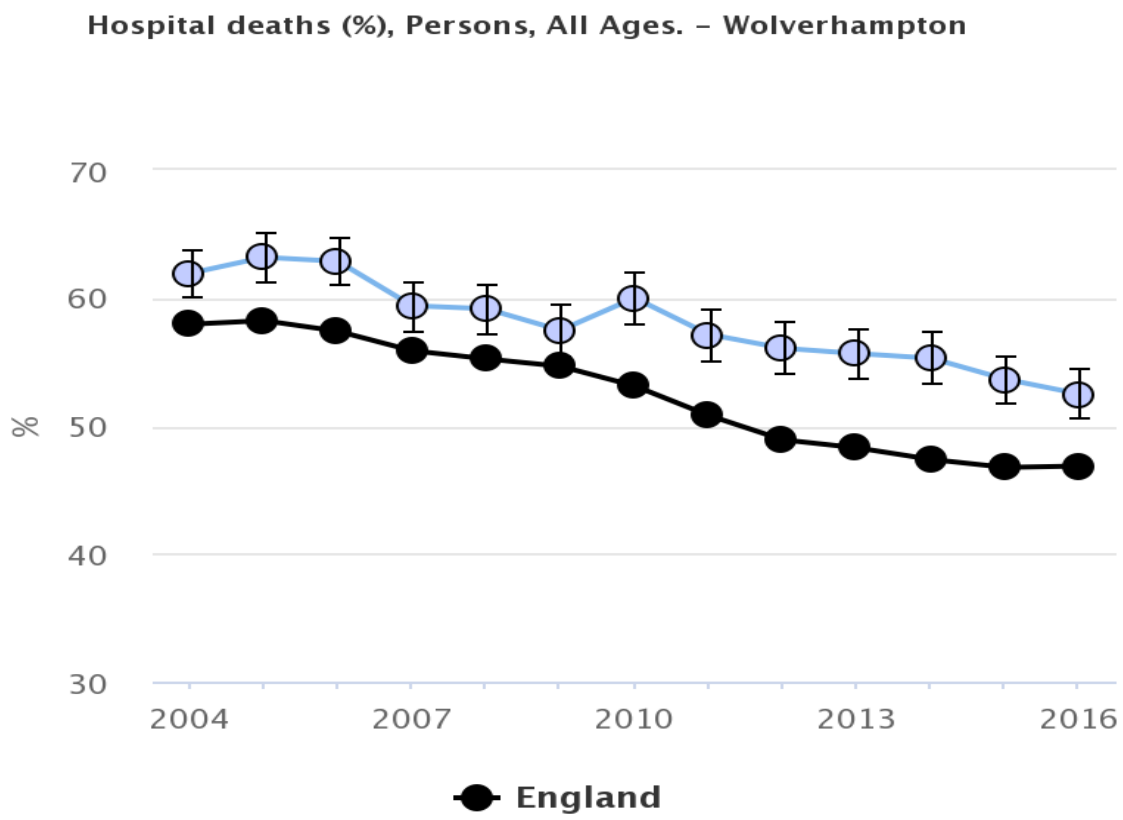
Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital deaths (%), Persons, Aged 0 - 64 years.	2016	↓	267	56.3%	48.4%	45.6%	32.1%		60.3%
Hospital deaths (%), Persons, Aged 65 - 74 years.	2016	↓	228	54.0%	50.6%	49.2%	35.2%		64.5%
Hospital deaths (%), Persons, Aged 75 - 84 years.	2016	↓	382	53.9%	53.1%	50.5%	40.6%		67.4%
Hospital deaths (%), Persons, Aged 85 years and over.	2016	↓	472	48.9%	46.3%	43.8%	29.8%		66.3%
Hospital deaths (%), Persons, All Ages.	2016	↓	1,349	52.5%	49.3%	46.9%	38.3%		63.1%
Care home deaths (%), Persons, Aged 0 - 64 years.	2016	→	18	3.8%	2.5%	2.9%	0.7%		13.0%
Care home deaths (%), Persons, Aged 65 - 74 years.	2016	→	33	7.8%	7.9%	8.6%	2.6%		19.2%
Care home deaths (%), Persons, Aged 75 - 84 years.	2016	↑	110	15.5%	17.2%	18.7%	4.1%		27.8%
Care home deaths (%), Persons, Aged 85 years and over.	2016	↑	309	32.0%	34.7%	36.7%	11.2%		50.9%
Care home deaths (%), Persons, All Ages.	2016	↑	470	18.3%	20.1%	21.8%	5.2%		32.8%
Home deaths (%), Persons, Aged 0 - 64 years.	2016	↑	142	30.0%	32.4%	33.9%	21.8%		44.7%
Home deaths (%), Persons, Aged 65 - 74 years.	2016	↑	113	26.8%	29.4%	30.3%	19.7%		39.7%
Home deaths (%), Persons, Aged 75 - 84 years.	2016	↑	167	23.6%	23.0%	23.8%	17.4%		30.7%
Home deaths (%), Persons, Aged 85 years and over.	2016	↑	155	16.1%	15.9%	16.4%	10.0%		28.4%
Home deaths (%), Persons, All Ages.	2016	↑	577	22.5%	22.8%	23.5%	17.1%		29.7%
Deaths in Other Places (%), Persons, Aged 0 - 64 years.	2016	→	27	5.7%	6.7%	7.2%	2.6%		13.9%
Deaths in Other Places (%), Persons Aged 65 - 74 years.	2016	→	6	1.4%	1.8%	2.0%	0.6%		9.7%
Deaths in Other Places (%), Persons, Aged 75 - 84 years	2016	→	11	1.55%	1.17%	1.36%	0.44%		4.94%
Deaths in Other Places (%), Persons, Aged 85 years and over.	2016	→	5	0.52%	0.79%	1.01%	0.25%		6.52%
Deaths in Other Places (%), Persons, All Ages.	2016	→	49	1.91%	1.98%	2.20%	1.11%		6.66%
Hospice deaths (%), Persons, Aged 0 - 64 years.	2016	→	20	4.2%	10.1%	10.4%	0.9%		18.5%
Hospice deaths (%), Persons, Aged 65 - 74 years.	2016	↑	42	10.0%	10.2%	10.0%	1.1%		31.9%
Hospice deaths (%), Persons, Aged 75 - 84 years.	2016	→	39	5.5%	5.5%	5.6%	0.8%		18.1%
Hospice deaths (%), Persons, Aged 85 years and over.	2016	→	24	2.49%	2.23%	2.08%	0.35%		8.38%
Hospice deaths (%), Persons, All Ages.	2016	↑	125	4.9%	5.8%	5.7%	0.2%		14.3%

Figure 6


Hospital deaths (%), Persons, All Ages. – Wolverhampton
70
60
50
40
30
%
2004
2007
2010
2013
2016
England