(Quality Committee (November 2022)) – Cover Sheet

Subject:	Hospital Standardised Mortality Ratio (HSMR) Update	**Date: 16th March 2023**	
Prepared By:	Nigel Marshall (Advisor to the Medical Director), John Tansley (Chair- Learning from Deaths)		
Approved By:	David Selwyn (Medical Director)		
Presented By:	David Selwyn / Nigel Marshall		
Purpose			
To provide Quality Committee with an update on the Hospital Standardised Mortality Ratio (HSMR) and schedule of work and to provide assurance around the quality of patient care		**Approval**	
		Assurance	
		Update	**X**
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X			**X**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
			X	

Risks/Issues	
Financial	**Potential litigation, on-going internal and external investigative costs**
Patient Impact	**Potentially, dependent on implications**
Staff Impact	**Limited**
Services	**Limited**
Reputational	**Significant, with external regulator interest**

Committees/groups where this item has been presented before

Original paper presented to Quality Committee (November 2020) with subsequent regular updates (previous update 19th November 2022).

Executive Summary

Summary:

- The Trust has seen a marginal improvement of the HSMR figure (compared to the previous month) although the current position remains that of "significantly higher than expected".
- The Standardised Hospital Mortality Index (SHMI) remains "as expected", although above 100.
- We continue to work closely with Dr Foster to ensure best use of data in supporting review of the overall picture, trends and outlier areas (both historical and current). This allows the Trust to focus on any perceived or actual hotspots or areas of concern.
- Actions have been commenced in several areas, through Learning from Deaths and a specifically designated working group, with particular focus on documentation, effective and accurate coding and specialist palliative care.

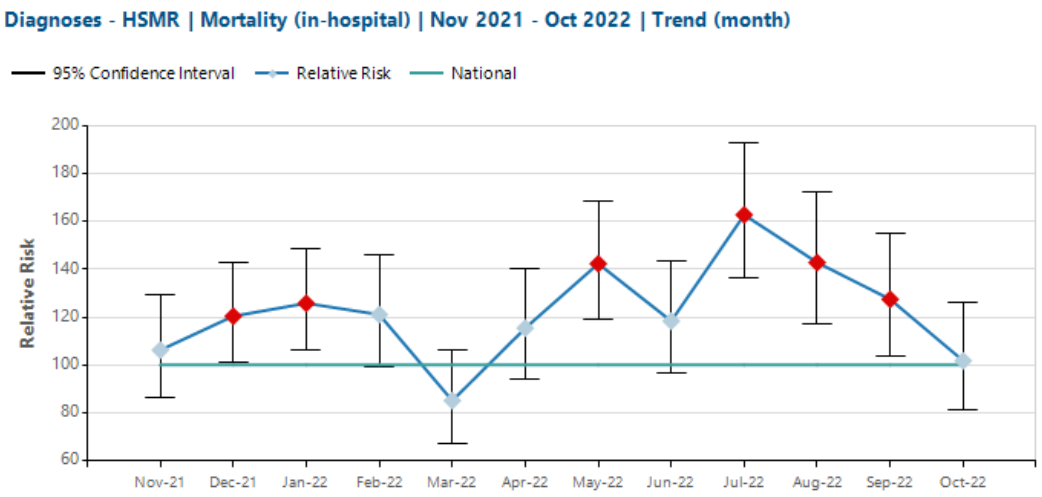
The Quality Committee is asked to:

- Acknowledge the challenge to reporting and interpretation of metrics and perceived trends.
- Recognise HSMR remains one of a number of metrics to support improvement.
- Note the 12-month rolling HSMR will likely show an increase in HSMR until the 12-month impact of any remedial actions to data quality, coding and other actions are realised.
- Support ongoing collaboration with Dr Foster data / reporting alongside use of Learning from Deaths in providing challenge, scrutiny and monitoring improvement.
- Note the actions and ongoing work related to identified drift and causation

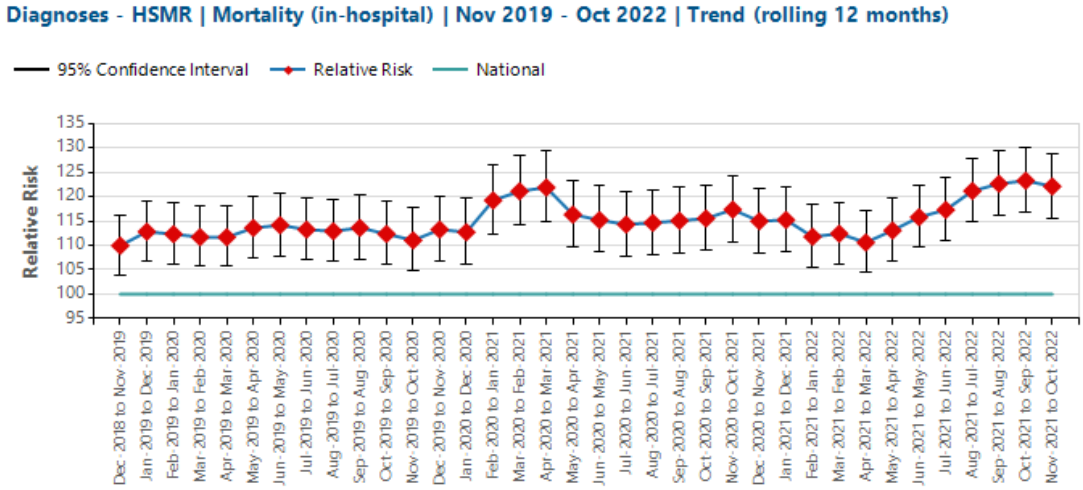
SFH HSMR Highlights:

- **HSMR** formal monthly reporting covers the 12-month period **Nov 2021 – Oct 2022**
  - **HSMR 122.1 (117.2 ex-covid)- Above Expected (previous report 124.2 (120.4))**
    - **HSMR for October 2022 = *101.75 (within expected) but 12.3% R69 codes**
  - **SMR 128.5 (122.1 ex-covid)- High (previous report 130.4 (123.1))**
    - **SMR for October 2022 = 118.2 (within expected)**
  - **SHMI (Aug 2022) = 102.73- As Expected (July 2022 = 101.91)**
- **HSMR Trends:**
  - Slight improvement in HSMR is thought to be due to the crude and expected rates converging (although both remain close to their 3-year peak and trough respectively)
  - The improvement in HSMR does appear to "buck" the national trend.
  - Trust remains higher than the peer, regional or national average.
  - Comparison with peers having the lowest palliative care coding (nationally) identifies SFHT to sit within the "funnel plot" and not statistically significant.
- **CUSUM alerts:**
  - 24 diagnosis groups breaching the 99% threshold (alert) over the 12-month period (to Oct-22), 3 diagnosis groups breaching 99.9%.
  - 3 CUSUM alerts at the 99% threshold for October -22
    - Liver disease (alcohol),
    - Other infections (incl. parasitic),
    - Residual codes (unclassified)
- **Coding Trends:**
  - An increase in residual codes has been identified, indicating a large amount of "Uncoded activity"; it is felt this is having a significant impact on HSMR.
  - Recommendation to monitor and if continues, apply a lag in data and analysis.
- **Co-morbidity coding:**
  - Felt to be a key area of HSMR influence; current evidence suggests SFHT have improved depth-of-coding for co-morbidity coding compared to previous month.
- **Palliative coding (Specialist Palliative Care- Z51.5)**:
  - Continues to show a low rate with both HSMR and across all activity. There is a continued marked difference between Trust and regional / national peers.
  - Highlighted as a key influencer on HSMR but not SHMI.
    - 2022/23 – SFHT = 0.94%, Peer = 1.99%, National = 2.26%

HSMR Monthly Trend (Nov 2021 – Oct 2022)

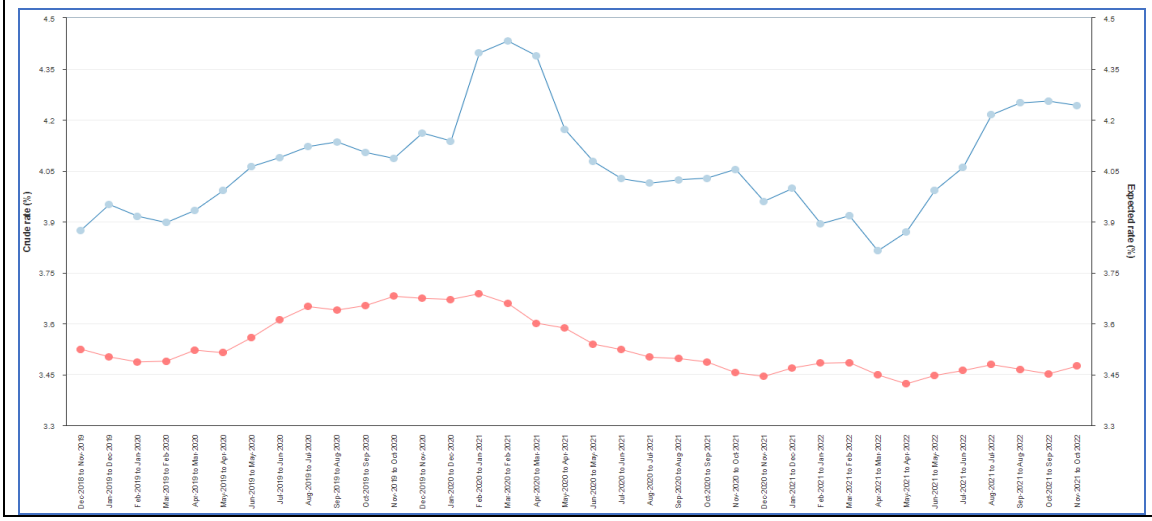


HSMR 12 month Rolling Trend (3-year comparison)

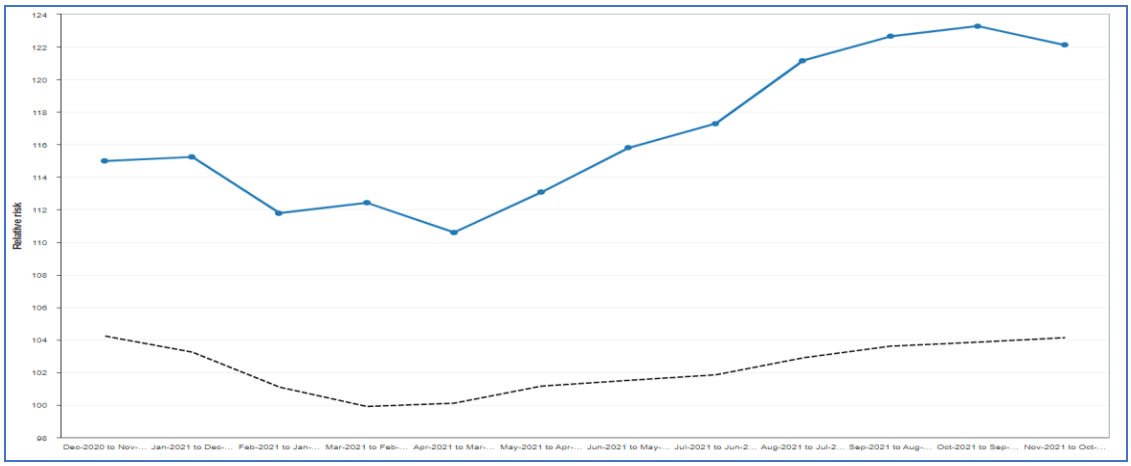


HSMR Crude rate comparison:

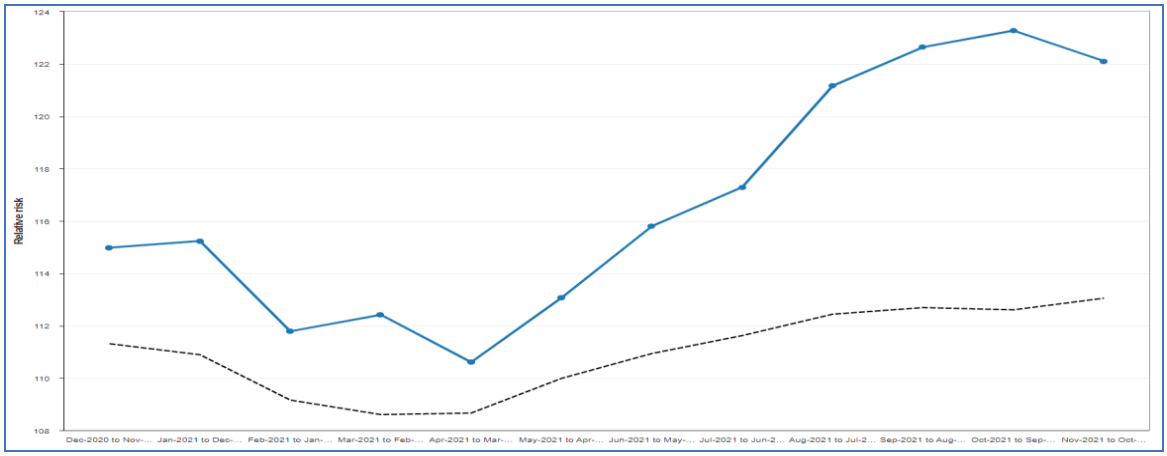
Sherwood Forest HSMR Crude Rate (blue) vs. Expected Rate (red) (Last 36 Months | Rolling Trend)



HSMR 12-month Peer Comparison:
Sherwood Forest (blue) vs. Peer Group (dashed black) (Last 12 Months | Rolling Trend)



HSMR Peer Comparison (Palliative):
Sherwood Forest (blue) vs. Palliative Peer Group (dashed black) (Last 12 Months | Rolling Trend)



Considered Root Causation and Actions to date:

HSMR outlier areas:
Learning from Deaths have instigated a process whereby diagnoses triggering in HSMR, CUSUM and SHMI, or other identified escalation, undergo focussed clinical case-note review in attempt to understand causation or separate signal from "noise". This has been undertaken in collaboration with Dr Foster reporting.
Current ongoing areas:

- Fractured Neck of Femur (#NOF)
- Liver disease (alcohol / other)
- Pleurisy, pneumothorax, pulmonary collapse

Initial feedback has indicated a need for clearer documentation of diagnosis and recognition / documentation of cases related to Palliative care / EOL.
An alert for "infections group" (non-HSMR group) was highlighted and provisional review undertaken through Dr Foster. Initial indications are that out-of-hospital deaths recorded for this group have triggered the alert and may benefit from a case-note review; this has been escalated through Learning for Deaths.

Diagnosis group "Other infections" have seen a rise, thought to be due to deaths occurring later in the clinical pathway and in higher risk groups (ie from sepsis, pneumonia and UTI).

Actions:

This area has been raised in Learning from Deaths and actioned for highlighting to the documentation working group as it is felt there may be a relationship with nomenclature and recording of uncertain diagnoses within the Primary Diagnosis field.

Palliative Care

Specialist Palliative Care (SPC) coding continues to show a low rate, regionally and nationally.

Actions:

- A coding standards review has been undertaken to establish accuracy and alignment with activity undertaken by Specialist Palliative Care; it is understood there is strong correlation of activity with coded documentation.
- Use of ICE (pathology requesting / reporting) to capture referrals and activity with a month-on-month increase being observed in SPC activity recording.
- There is reported variation amongst specialty areas for uptake of SPC involvement; latest approaches to improve support and take-up include:
  - Inclusion within induction programme
  - Presentation at Med Managers (April 2023)- understanding SPC, offer of support and identification of opportunities (this will improve SPC coding)
  - Improvement to documentation- emphasis on clarity, designated SPC sticker use
  - Recording of telephone consultation / advice

Further work is being planned around:

- Identification of patients at the "Front door", including frequent attenders (indicator of potential EOL or need for targeted palliative support)
- Patients with non-cancer diagnoses
- Advice booklet

Update from an external quality control coding audit is awaited.

A ReSPECT (**RE**commended **S**ummary **P**lan for **E**scalation and **T**reatment) training package has been developed, intranet page established and wider communication undertaken relating to End of Life.

Co-morbidity capture (missing coded activity or diagnoses):

Subsequent to an initial offer of review from an external source, internal work has been undertaken, in collaboration with the coding team, Chief Digital Information Officer and Data / Information Analytics teams, to identify "missed co-morbidity coding".

Missed co-morbidities, as identified through Charlson Index, can be associated with potential reduced perceived mortality risk and resulting lower expected value. As a result, the Relative Risk (observed: expected) can increase disproportionately and felt not to be reflective of true case-mix and HSMR.

Initial reflection of latest 1 month data:

- 25% co-morbidities (19000 / 79000) missed, involving up to 30% episodes of care (4500/15000)
- Potential financial impact as a result of codes being aligned to activity tariff
- Missed diagnosis leads to discrepancies in quality of data

Opportunities for accurate coding are being considered with regard to local pathways and how these may lead to additional Finished Consultant Episodes (FCE) and earlier "first" FCE / primary diagnosis.

Actions:

- Continue review of monthly data and report into Learning from Deaths
- Use of Medical Managers / Grand Round to communicate importance of documentation in addition to supporting identification and recording of co-morbidities
- Documentation working group and engagement with Primary Care to work towards improving communication and consistency of information.

Documentation Working \Group:
Documentation related to health records, including effective communication and clear documentation, is reported to be amongst the top areas for incidents.
A working party has been established, under the direction of the Deputy MD, to support identification of improvement and drive change.
Actions:

- Areas of focus include:
    - Review of issues related to documentation
    - Simplification of documentation, with particular reference to admission
    - Review of medical admission- "hybrid" (SFH / NUH) clerking to ensure consistency but relevant information captured and remains usable.

Specific points, under review by members, are awaiting further discussion with, hopeful, incorporation of ideas in an amended admissions clerking book.
The group is mindful of other sources of information (EPMA, Nerve-centre, SystmOne) and ability to capture this within the relevant documentation material.

Primary / Secondary Care Interface:
It is recognised there is a need to work across the whole pathway of patient care.
Actions:

- Further engagement is being undertaken towards improving relationships and impact at the interface between the Acute Trust (SFHT) and stakeholders (Primary Care / Community)
- This includes improvements in communication, development of local pathways, referral / discharge information (consistency and accuracy).

Summary of Actions:

- Deep-dive analysis and review undertaken via learning from deaths and HSMR sub-group. Coding review and "look backs" in progress, alongside engagement discussions with clinical teams around coding diagnosis, co-morbidities and admission documentation completion
- Discussions between external palliative care service around service delivery whilst ensuring contacts with specialist palliative care and End of Life (EOL) services are recorded and subsequently coded
- Clinically led task and finish group to review admission documentation under DMD. Focussed clinical reviews requested
- Report into "missed coding" due to non-documentation of chronic disease / other co-morbidities
- Continued triangulation with other quality markers to ensure earlier identification of potential or actual patient harm

Timescale:

- Targeted reviews are agreed to report into Learning from Deaths the following month (Ongoing)
- Documentation working party (T&F group) established with good initial engagement from clinical areas.
- Rolling 12m HSMR negates any immediate impact and project work is anticipated to take 12m
- Although service changes are intended to see more immediate "on the ground" impact, it is likely this will not reflect in HSMR trends for up to 12 months.

Other information / points for consideration:

- Learning from Deaths continues to act as the conduit for information and intelligence feeds from different modalities and is the forum whereby specialty and divisional learning is collated and shared.

- The Working group, led by the Deputy Medical Director, is intended to be a resource by which senior level discussion can lead to effective turnaround of ideas and resulting action.

Quality Committee is asked to:

- Acknowledge the ongoing challenge and work being undertaken as described above
- **Review the additional presentation** from Dr Foster on the wide variation in palliative care coding and implications potentially for SFH (**Appendix 1- PowerPoint**)