Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Hospital Standardised Mortality Ratio Update	**Date: 3rd December 2020**	
Prepared By:	Nigel Marshall/ David Selwyn		
Approved By:	David Selwyn		
Presented By:	David Selwyn		
Purpose			
To provide Trust Board with an update on the schedule of work proposed to perform a deep dive investigation of the possible causes of our raised HSMR		**Approval**	
		Assurance	
		Update	
		Consider	X

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	**Potentially,**
Patient Impact	**Potentially, dependent on findings and implications**
Staff Impact	**Limited**
Services	**Limited**
Reputational	**Significant, with external regulator interest**

Committees/groups where this item has been presented before

Draft paper shared with CQC, amended and circulated to Quality Committee NED's Quality Committee

Executive Summary

The Trust Hospital Standardised Mortality Ratio (HSMR) remains elevated and despite previous investigative work, the causes and implications of this remain unclear.

This paper outlines the investigative work planned to identify causes and propose actions and remedies and to address the increased HSMR.

Trust board is asked to note the update and support the direction of travel, specifically:

- The paper builds on the initial proposal of investigative work previously shared with CQC (Oct 2020)
- SHMI remains within expected limits
- NHSE mandated learning from deaths program has not yielded any significant patient concerns
- Investigative work consists of a review of:
    - Data submitted to Dr Foster and in house coding aspects with particular focus on the impact of palliative care coding
    - A deep dive analysis of the SFH learning from deaths process including; mortality review screening, tool, Structured Judgment Case Review process and quality assurance, learning from deaths escalation, actions and learning cascaded and impact of shared learning
- It is anticipated that a number of short, medium and longer term actions will be recommended but in the meantime it should be noted that the HSMR rate will remain elevated and is likely to increase as a result of Covid wave 2

Further updates on this work will be provided via the Quality Committee and quarterly to Trust Board.

Background

Sherwood Forest Hospitals NHS Foundation Trust (SFH) had been experiencing a rising trend in **Hospital Standardised Mortality Ratio** (HSMR) and, although there has been an observed reduction over the past two months (3 data points), it continues to trigger as statistically **high at 109.5** (previously 112.3), where normal is 100, and is one of 3 organisations highlighted across the regional peer group. Taken from latest Dr Foster Report (November 2020 - July 2020 data):

There are 7 flagged diagnosis groups (CUSUM alerts) with excess mortality;

- Gastrointestinal haemorrhage (Existing)
- Abdominal pain
- Liver disease, alcohol related (Existing)
- Cancer of liver and intrahepatic bile duct
- Nephritis, nephrosis, renal sclerosis
- Chronic renal failure
- Viral infection (driven primarily by Covid-19)

There are 2 diagnosis groups previously flagged that have been or are currently being investigated:

- Fractured neck of femur (operated)
- Non- specific respiratory disease

The **SMR also remains high** (110.4), although is following the same downward trajectory as HSMR. Its increase is felt to be driven by Covid mortality and fall in elective and non-elective activity (denominator). With Covid activity and mortality removed the revised SMR at July would have been 105.1 and as expected; this represents a significant fall.

Other key points:

- Without Covid -19 activity or mortality, HSMR at July would be 106.8 (previously 108.3)
- SFH continues to be one of, if not, the lowest palliative care coders nationally; non-elective spells being 1.3 vs. 4.3% (nationally) and non-elective deaths 10.1 vs. 33.8% (nationally)
- Proportion of HSMR with 20+ comorbidity score is high; 19.3 vs. 14.0% (nationally), suggesting satisfactory co-morbidity coding.
- Weekend mortality previously was not elevated but more recently has climbed.
- The Standardised Hospital Mortality Index (SHMI) is currently 96.97 (prev. 95.60) and within expected range.

Background summary:

- Although there are currently no clear indications, the relationship between the elevated HSMR and SHMI being within expected limits constitutes part of the more focused discussion with Dr Foster to guide additional scrutiny moving forwards.
- The Trust HSMR remains high and further investigation is required to help explain this.

Limitations of Data and Current Processes

SFH continues to work closely with Dr Foster, a provider of healthcare information and data analytics in the UK, to support understanding of mortality data and identify key areas of focus. It is, however, recognised the data is limited in understanding where wider, underlying, contextual issues arise. In addition to addressing outlying areas there is specific focus on coding, including the impact of COVID and palliative care. Whilst this may improve the HSMR there is a danger of trying to “make something fit” with the data potentially being misleading.

In order for the data to be meaningful we need to understand and acknowledge how it applies to "real-life" cases and, from this, identify learning, develop plans and implement change (where applicable). In considering the whole pathway, a tiered review / scrutiny process, of which the Structured Judgement Case Reviews (SJCRs / SJRs) are a key part, is required. Initial reviews have indicated questionability of the SJCR process, which will be explored as part of the proposals below.

The HSMR can only reveal some of the picture and needs to be taken in the context of the whole approach to our Learning from Deaths. The following are key elements in providing greater assurance, will provide greater confidence in the HSMR and help ensure data is used effectively and be more meaningful:

- Robust approach to early identification of issues, highlighted variation or trends
- Consistent process for review (to include quality and governance)
- Effective learning, communication and application of any new measures / practice (including use of best practice and explanation of rationales)
- Culture and organisational approach to assurance

Planned Investigative Work and Actions:

Initial investigative reviews would be conducted within the Trust environment, using the independence of the Trust Clinical Director for Patient Safety, Project Advisor and Medical Examiner service, in the form of an Independent Review Panel, to ensure consistency and help limit bias. There needs to be wider accountability to ensure processes are in accordance with best-practice (evidence based) methodology; the need for external agency or wider review will be part of second phase considerations. We have agreement with QEH, King's Lynn to undertake joint and independently verified reviews.

The internal approach to HSMR and wider assurance is felt to sit within two distinct spheres fit within the following timescales:

- **Short term**- Targeted / focused HSMR review and analysis of specific outlier areas
  - To be completed within 3 months from approval
- **Long term**- Wider pathway and process evaluation to provide system assurance
  - For full mobilisation by April 2021

Short term - Targeted / Focused review:

This would consist of 3 elements with an expected time frame of 3 months from approval:

- **Focused meeting with Dr Foster:**
  - To consider key highlighted areas, better understand the data presented, and determine the relevance of any trends, what is within our control and how these may feed into proposed actions.
  - Current identified areas for discussion:
    1. Palliative care- review the impact of un-coded Palliative care in relation to HSMR
    2. Weekend Mortality- to understand what may be driving the variation as reported
    3. September 2019 HSMR peak
    4. Diagnosis group reviews
    5. COVID-19

Note: It has been requested for Dr Foster to present more "context" around data, specifically, that which is pertinent to the current trending HSMR and outlier areas.

- **Scrutiny of key outlier "diagnosis groups"** to include re-evaluation, using SJCRs, with particular

emphasis on:
  - Accuracy of records
  - Ensuring correct diagnosis and coding, including co-morbidities
  - Review of case-mix to highlight trends, understand demographic challenges etc.
  - Review of process and pathways- in, out of hospital and system-wide

- **Review of targeted historical outlier areas:**
  - Fractured Neck of Femur (#NOF):
    1. Although mortality is no longer on the "flagged list" days to theatre remains significantly high.
    2. Further analysis and review of the previous May 2019 and September 2019 peaks, either against previously carried out SJRs or as new independent scrutiny in order to ascertain learning points and subsequent actions.

Expected outcomes would be:
- Contextual identification of priority areas for targeted review and scrutiny
- Consistent approach to scrutiny with an emphasis on SJR process, enabling independent holistic review, wider education, learning and assurance with regard to a clear pathway for identifying outcomes and actions.
- Assurance improvements in HSMR / mortality, for previously raised areas, are acknowledged, understood and, where possible, explained.

Longer term - process and pathway:

Requires a consistent approach to working, reliance on greater transparency and improved engagement with teams directly involved in the management of patients. Importantly, there is potential to clarify the process and, with organisational "buy-in", create a robust system by which greater assurance can be given.

Suggested re-defining of structured approach to cases:

Stage 1: Initial Review / Scrutiny of ALL deaths
- All hospital (and community deaths as of 04/21) to go through Medical Examiner (ME) service initial scrutiny process. This ensures:
  - Capture of all deaths to act as a denominator and support identification of specific trends or areas of focus
  - A consistent "first level" of INDEPENDENT scrutiny of management and establishes agreed cause of death
  - Connection is maintained with Family to address concerns and link in with Learning from Deaths
- Early identification of Stage 1 review criteria for SJR (including SI, LeDeR, Mental Health)
- Opportunity to pick-up pre-mortality issues and queries, should these require discussion
- ME database to support data themes and link in with Dr Foster

Stage 2: SJR (Structured Judgement Review)
- Carried out by appropriate members of clinical team
- Appropriate training, support to be provided in order to ensure consistent and effective review process
- Help limit "bias" through use of recognised and agreed template format
- Consider whole process approach, including pre-hospital (community) element as an important component within the overall patient journey.

Stage 3: Avoidability Assessment

- Cases as highlighted from SJR
- Identification of potential variation from normal "expected" care

Stage 4: Review of SJR / AA Themes in Learning from Deaths group

- Reporting of summary, recommendations and understanding impact of any actions
- Sign off or escalation as necessary

Expected outcomes of the Longer Term Process:

- To further develop a culture of transparency and engagement; ensuring everyone is on-board and not only understands the significance of HSMRs but also the relevance to them as individuals (as part of a wider team, organisation) and, as important, the population we serve.
- For this to provide a foundation for "business as usual" or longer term working and provide both assurance and a clear mechanism for early identification of issues at different levels.

Note: It is hoped a policy will be developed, for agreement by all specialities, with regard to methodology, pathway / process for escalation, identification of learning, action and demonstration (with timescales) these elements have been carried out.

Timescales for each section

Focused review (for completion by 1.2.2021 (3 months))

- Month 1 (by 1.12.2020)-
    - Dr Foster discussion- a meeting was held on 5th November 2020 where deeper understanding of how the data can be used, interpreted and intelligence fed into highlighted area internal reviews discussed. A small working group are focusing on specific areas to understand the impact of these on the trust HSMR in addition to identifying priorities and key discussion points for the next Dr Foster report and Learning from Deaths meeting in December 2020.
- Months 1-3 (1.11.20 – 1.2.2021)
    - Scrutiny of outlier areas, as highlighted by Learning from Deaths group, firstly by internal speciality team and followed up with independent review by SJCR Review Panel (see above)
    - Current areas of review:
        1. #NOF (Fractured neck of femur)
        2. Gastro-intestinal haemorrhage / Liver Disease (alcohol related)

Longer term process and pathway (to be fully mobilised by April 2021)

- Iterative process and work on this has already been progressed.
- The ME service now covers Monday-Friday (with Monday reviewing weekend cases in addition to duties of that particular day).
- Currently all deaths are entering the ME Office with the aim to scrutinise all cases
- Specialist teams OR the ME may raise the need for SJR or further review.
- SJRs to be completed, reviewed by SJCR review panel and reports fed into the LfD Group
- The ME Office will, at the same time, highlight any trends, concerns or areas of perceived good practice not raised elsewhere
- The Learning from Deaths (LfD) group will summarise outcomes of any SJR reviews, be the forum for discussion, highlight need for more detailed scrutiny and, as per pre-agreed trust-wide policy (to be established by April 2021), capture agreed actions as part of the wider assurance process.

Conclusion and recommendations

The current raised HSMR and outlier status of the trust remains a concern and, although complex, it is recognised there is a need to demonstrate:

- a better understanding of what the data is telling us,
- action in response to identified opportunity or need,
- learning (where evident) and
- subsequent change to process or management approach to improve consistency and care(where applicable)

To date there have been several speciality focused reviews to consider areas previously highlighted but learning, action as a result and impact of this is not apparent. There should be a proven ability to challenge internally, identify learning from past cases and showcase a change in culture to that of a more open and transparent approach to learning from deaths.

Whilst the impact of Covid cases and Palliative coding will account for some of the rise in HSMR these need to be considered within the focused reviews to understand the potential wider impact and relevance.

To embed a culture of good practice, learning and ensure actions are realised (and mobilised) the approach is to be taken in two ways:

- Short term - review and scrutiny of the highlighted / outlier areas
- Long term – re-evaluation of whole review process in order to:
    - provide assurance
    - demonstrate clear systematic methodology for learning from deaths,
    - identify good practice, changes to current practice and understand the impact of any actions
    - effectively communicate and share learning in an open / transparent manner

Although the early frameworks of the above processes are already in place the real challenge is about consistency, improving engagement and embedding this into the system wide culture of the organisation.

The structured approach to learning through a fully supported and functioning ME service, feeding into the LfD group, is pivotal in providing an effective and robust process for wider assurance.

If agreed, the longer-term process (Stages 1-4) should, in theory, mean the need for focused reviews will be less frequent but, where required, easier to carry out.

It is recognised that this work is likely to generate a requirement for additional resource, which will require Quality Committee support.

Additional resource / requirements:

- Multi-disciplinary involvement to aid development of trust-wide policy for SJR scrutiny and escalation
- Medical Examiner Service – request for additional sessions to ensure service stability and flexibility to allow for leave / colleague absence, thereby maintaining comprehensive service provision and effective Stage 1 scrutiny
- Additional support for critical reviews in speciality areas (could be evidenced by the delay in GI bleed from request to presentation); this includes admin to support logistics, flow and data collection.

• Consideration of Trust / Divisional SJCR lead although this could be mitigated with engagement from clinical / division leads alongside robust implementation of longer-term process and SJCR review panel. • Continuation of MD Project Advisor role • Additional MD office secretarial support