Appendix 1

(Quality Committee (March 2022)) - Cover Sheet

Subject:	Hospital Standardised Mortality Ratio (HSMR) Update	**Date: 15th March 2022**	
Prepared By:	Nigel Marshall (Medical Examiner and Project Advisor to the Medical Director)		
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		**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**
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 updates (previous update 8th November 2021).

Executive Summary

Summary:

- New methodology, applied by Dr Foster, is now being used for monthly reporting. However, the presence of a high number of residual codes and issues with data submission have led to the need to lag data reporting by one-month. This is actively being investigated between the Trust and Dr Foster.
- Latest HSMR has seen a recent rise but there are a few factors impacting this, including the recent re-modelling (see below).
- SHMI remains "as expected"
- 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)

The Quality Committee is asked to:

- Note recent changes to methodology and potential impact on relative risk seen by the Trust, but also nationally.
- Acknowledge the challenge to accurate and reporting due to residual code issues.
- Recognise the HSMR continues to be utilised in supporting identification and pursuit of areas where we can continue to improve the quality of our patient care.
- Note the update to project / focus areas and continued challenge, into the system, for comprehensive and achievable action plans around areas highlighted for improvement.
- Support continued monitoring, using the Learning from Deaths (LfD) Group as a vehicle to

provide formal challenge and scrutiny.

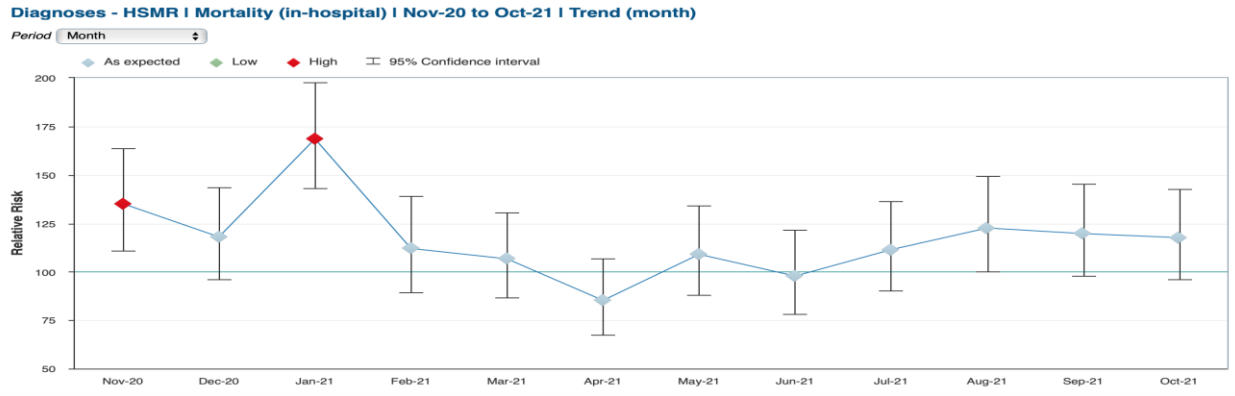
Recent HSMR changes:

- April 2020 was reported as an exceptional month, seeing high deaths against low admissions; this month has now moved out of the dataset (most recent year of benchmarking).
- The modelling is still "volatile" as it includes COVID (ref April 2020). However, the previous "over-adjustment", as a result of Covid, is felt to have now "normalised" BUT for those Trusts with high Covid activity (incl. SFHT) there may be a disproportionate rise compared to peers.
- National HSMR has now reverted to a baseline of 100, potentially providing assurance of the increasing stability of the model.
- An overall, greater observed increase volume of deaths v a lower expected (due to historical and adjustments) has given a disproportionate rise in Relative Risk (National 2-point change v SFH 4-point change). A decreasing trend in palliative care coding has also resulted in a decreasing trend in expected numbers which is different to peers (regional and national), further adding to the disproportionate rise.
- Despite this rise in Relative Risk, the actual position of the trust, in terms of benchmarking against peers, has seen little movement in the last few months indicating a degree of stability.

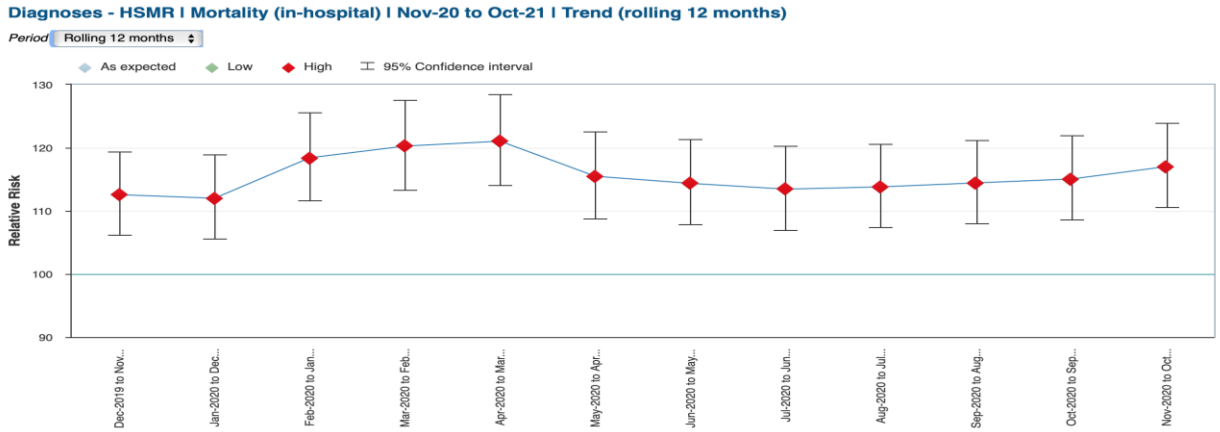
SFH HSMR Highlights:

- Latest HSMR monthly reporting covers the 12-month period Nov 2020 – Oct 2021
    - High numbers of residual codes were reported in latest data; a one-month "lag" is currently being used to show the most accurate and up to date reflection of position.
    - In addition, review highlighted potential incomplete data submission (Month 8), further supporting the need to time-lag reporting.
- Nationally, many trusts have seen a rise in HSMR.
- HSMR at SFHT has risen with a few factors impacting this (highlighted below), including the latest approach to modelling.
        - **HSMR 117.0 (108.8 ex-covid)- Above Expected**
            - To be "as expected", there would need to be a 9-10pt reduction.
        - **SMR 123.2 (109.3 ex-covid)- High**
        - **SHMI 97.45- As Expected**
- Reporting (February 2022) highlights 7 alerting diagnosis groups, including:
    - Inflammation of the eye, Coagulation / Haemorrhagic disorders, Viral infections, Epilepsy, Respiratory failure, Deficiency and anaemia, COPD (see below)
    - **Removal of Covid-19 activity removes epilepsy and viral infections form these alerts.
- Low Palliative coding continues to be highlighted as a key influencer on HSMR but not SHMI.

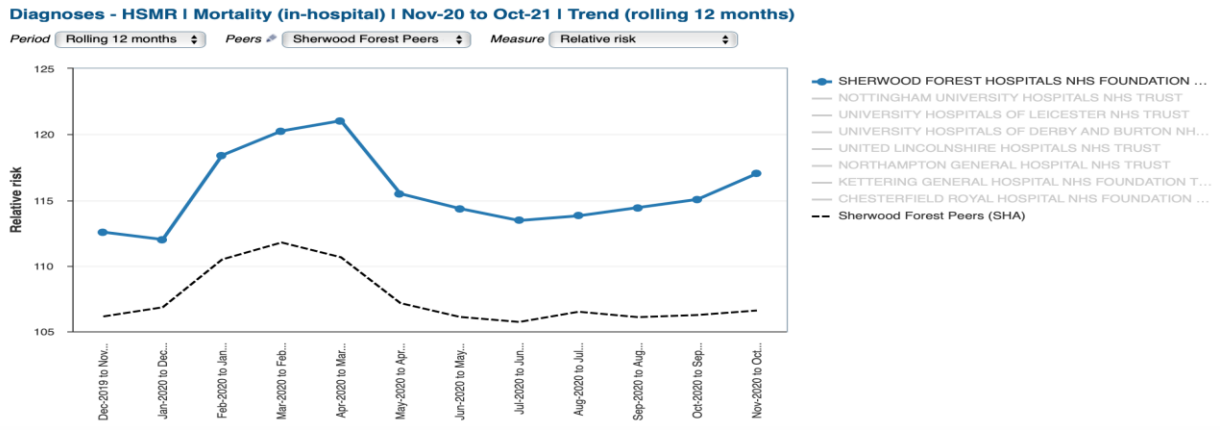
HSMR Monthly Trend (Nov 2020 – Oct 2021)



HSMR 12 month Rolling Trend (Nov 20-Oct 21)



HSMR 12-month Peer comparison



<u>Covid reporting:</u>

- Covid appears to have a greater impact on HSMR in Trusts where they have seen a "3rd spike". SFHT activity is currently being evaluated against peer experience.
- The approach to coding of Covid diagnosis is thought to be different in some Hospital Trusts. Initial scoping would suggest SFH are coding and maintaining codes correctly and in accordance with guidelines. This is reassuring but potentially makes SFH figures appear worse when compared to others who aren't necessarily following the rules in the same way.
- SFHT has seen rates of 2.1% v 1.6% nationally- this will have impact on overall HSMR and,

alongside our position against peers.

Outlier / Project Areas:

New outlier alerts-

- New HSMR outliers have created unusual alerts with small volumes of deaths. These have low impact on overall HSMR but still do contribute to the gap between observed and expected.
    - Areas, including Eye infection (3 patients), Coagulation (4 patients) and Epilepsy (8 patients), are awaiting case notes for review to ascertain whether coding errors exist (especially regarding eye infection as this would not be a typical group)

Ca Breast-

- The value has fallen to "as expected" (and remained) with a recent increased volume activity
- The suggestion has been to monitor trend whilst considering potential Covid effect (including later presentation, greater number).

COPD-

- Remains an alert but Relative Risk is decreasing
- Primary crude rate is increased but spells have decreased.
- There is a divergent trend when compared to peers (especially expected)
- A meeting was held 01/03/2022 with the Trust Respiratory Clinical Lead who had undertaken a review and felt there were no clear clinical management issues of concern but a question around clerking documentation, use of COPD diagnosis and appropriate coding. This is being discussed in a coding meeting later this week and further review continues.
- Case-mix and Covid diagnosis are also felt to be key influencers in this domain.

ALD-

- Trend shows a decreased Relative Risk to an "as expected" range
- Work continues to look at general management, demand factors and bundle / front door approach but also outside factors; however, nothing new has been raised through data.
- We are awaiting a report from Specialty teams (Front door / Gastro) as to progress with bundles and management approach.

Fractured Neck of Femur (#NOF)-

- The Relative Risk is "as expected" although a recent slight increase has been observed, coupled with the historical presence of 3 spikes (Jan 21, June 21, Oct 21)
- The increase is thought to be a result of observed - expected divergence over the past 3 months. It has been suggested to monitor activity data / trends and link in with intelligence received from Medical Examiner / Learning from Deaths.
- Orthopaedics, Anaesthetics and Ortho-geriatrics have made progress with developing a collaborative approach (MDT) to decision making (appropriate, shared and documented rationale) – feedback has been positive and there is an action to mobilise immediately.

Palliative Care-

- Palliative care coding remains much lower than peers and is felt to have a definite impact on HSMR, both overall but within diagnosis groups.
    - There are plans to assess the inclusion rules around palliative care in the Dr Foster risk model, but a decision has yet to be made and there is no timeline for implementation.
- Internally, a "collaborative" meeting between Specialist Palliative Care, and the Trust (including End of Life Teams and coding team) is due. It is hoped to identify what activity is taking place, documentation and understand capture of coding for data submission.
    - A progress report has been requested regarding mobilisation of agreed actions.

- We have discussed, with Dr Foster, the possibility of looking at other trust models for palliative care provision and coding (recognising the inter-dependency) but also to use the SHMI in conjunction with the HSMR as it is thought this will help support understanding of impact.

Other points for consideration:

- What is driving the HSMR (in addition to or including above)?
    - It is felt there is a need to recognising the challenges in using HSMR data, via Dr Foster, as the primary (or even sole) driver to highlight areas for further evaluation. The lag between reporting and original activity often means any spike / trend occurred months in the past.
    - Work is being undertaken to identify how to gain more effective (and timely) intelligence, including triangulation between Medical Examiner scrutiny, in-house specialty review (including SJR process and regular sample audit / review) and trends identified through Learning from Deaths and other processes. It is hoped, this will support identification of issues, sub-optimal management or good practice (i.e., not just related to death) in a more effective manner.
    - It is thought Dr Foster data (and HSMR) should be considered, and used, as more of a "sense check" to support earlier understanding of what may be happening and provide supportive evidence of change due to prior actions.
- The SFH "expected" value is far lower than other trusts with similar activity – this will have a disproportionate resultant Relative Risk.
    - We are trying to understand whether our expected value / case-mix is correct.
    - Palliative care coding is likely to be a main contributor to the lower expected figure.
    - Dr Foster have seen a greater proportion, compared to other trusts, of diagnosis groups with a noticeably different diagnosis on discharge. This may be a result of our methods and point for data capture, related to patient "flow".

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- Acknowledge the challenge to accurate and reporting due to residual code issues.
- Recognise the HSMR continues to be utilised in supporting identification and pursuit of areas where we can continue to improve the quality of our patient care.
- Note the update to project / focus areas and continued challenge, into the system, for comprehensive and achievable action plans around areas highlighted for improvement.
- Support continued monitoring, using the Learning from Deaths (LfD) Group as a vehicle to provide formal challenge and scrutiny.
- Acknowledge that we continue to monitor for any triangulation of quality markers which might support the higher than anticipated HSMR