

Medical Director's Report

Board of Directors September 2017

Mortality Update

Overall HSMR for the trust remains in the 'as expected' range at 95.9. The figure for RBH (excluding Christchurch and the Macmillan unit) is 88.4 and in the 'better than expected range'. For the complete financial year 16-17 the Trust's HSMR was rated significantly better than expected for the first time. It is important to note that HSMR has been better than the national average consistently over the last 12 months.

Importantly crude death is stable/falling at 1.09% as are the number of deaths within 36. Reassurance is provided by the continued SHMI position and number of re-admissions which do not suggest that there are inappropriate or late deaths in the community.

We continue to review any alerts in diagnostic groups by undertaking a case note review for any new alerts. For repeat alerts this is done in conjunction with a review of any previous action plans to ensure that all actions have been completed. For example, a recent alert in Peripheral arterial disease and thrombosis has an outstanding action to improve medical (physician) support to vascular patients for which funding has been identified but the post is to be filled.

Learning from Deaths

From this month it is now mandatory for the Trust to centrally report mortality data to include:

Number of deaths

Number of deaths subject to review

Number of deaths where deficiencies in care were identified

Actions arising from any reviews

There is a drive to ensure that processes across Wessex are working in similar ways to allow direct comparisons between Trusts. More importantly this should ensure system learning from deaths rather than for individual organisations. For example, care may have been good but death inevitable by the point of admission but with modifiable features within out of hospital care.

There are between 106-160 deaths per month in the Trust. We achieve up to a 60% review rate of all deaths but there is a significant lag in these being completed ie full cycle of clinician review, mortality lead sign off and presentation at mortality and morbidity

meetings. The rising number of Coroner requested post mortems and the delays in receiving post mortem reports is likely to impact on this further as we have already seen some decline in the timeliness of reviews.

Of 851 deaths reviewed in the last 12 months 68 were graded as Grade 1 where there were some gaps in care but not significantly contributing to death. Only 5 were graded as 2 which indicates a possibly avoidable death. This equates to around 0.6% of deaths reviewed which is lower than the 3.6% reported in two key national studies but in keeping with what has been reported by other organisations piloting the Royal College of Physicians Structured Judgement review. We suspect that 'second look' and wider system consideration being introduced as part of the Medical Examiners Group may increase this number.

Sep-16	106	34	32.1%
Oct-16	132	61	46.2%
Nov-16	125	73	58.4%
Dec-16	135	71	52.6%
Jan-17	169	88	52.1%
Feb-17	158	73	46.2%
Mar-17	132	57	43.2%
Apr-17	129	66	51.2%
May-17	139	57	41.0%
Jun-17	113	16	14.2%
Jul-17	107	10	9.3%
Aug-17	130	0	0.0%

E-mortality review completion -Overall rate 38.5% in the last year

As part of this process any deaths with any 'triggers' reading the quality of care will feed in to a process aligned to our serious incident investigation process. This will allow timely recognition of deaths with avoidable features, ensure that family's voices are heard and questions answered and allow key learning to be shared in a similar format.

SACT data

The national report on Systemic Anti-Cancer Treatment has been awaited for some time. In the previous report the Trust had been identified as an outlier relating to documentation of intention to treat (cure versus symptom control). We have now been notified that the data is likely to be released within the next few weeks. We have received no queries about our data or indications that we are likely to be an outlier but await the formal report