Airedale NHS
NHS Foundation Trust

Report to:	Board of Directors				
Date of Meeting:	25 January 2017				
Report Title:	Mortality Scorecard				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X	X				
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Executive Sponsor (presenting):	Mr. Karl Mainprize Executive Medical Director				
Appendices (list if applicable):	Appendix 1; Mortality Scorecard				

Purpose of the Report

To outline currently available mortality data.

Key points for discussion

There were 77 reported deaths across the Trust during December 2016; one of these occurred following a planned admission with 12 deaths occurring within two days of admission. However there were no Maternal or Paediatric deaths.

The crude mortality rate is the percentage of patients admitted to the Trust who die whilst an inpatient and the current rate for the Trust is 1.48%. Peer benchmarking is available, three months in arrears; the Trust remains consistently below that of all acute providers in England. It is considered a low crude mortality rate is a good indicator of quality care within an acute Trust.

The Summary Hospital Level Mortality Indicator (SHMI) from NHS Digital is released quarterly and is six months in arrears. The latest data covering the period July 2015 to June 2016 is included within Appendix 1 and compares the actual number of patients who die following hospitalization with the number that would be expected to die.

However, it must be noted the difference between the number of observed and expected deaths cannot be interpreted as the number of avoidable deaths. This can only be determined by detailed case note reviews.

Recommendation

The Board of Directors is asked to receive and note the scorecard.

Mortality Scorecard: to December 2016

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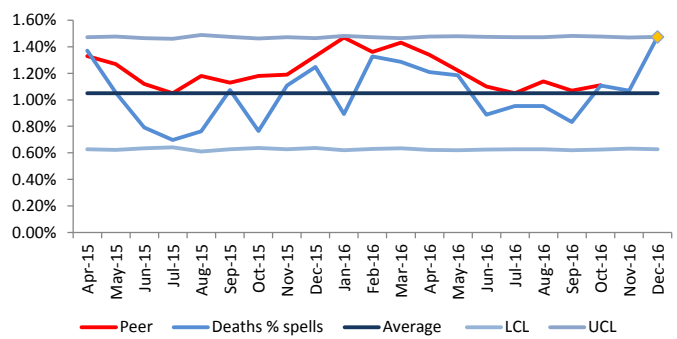
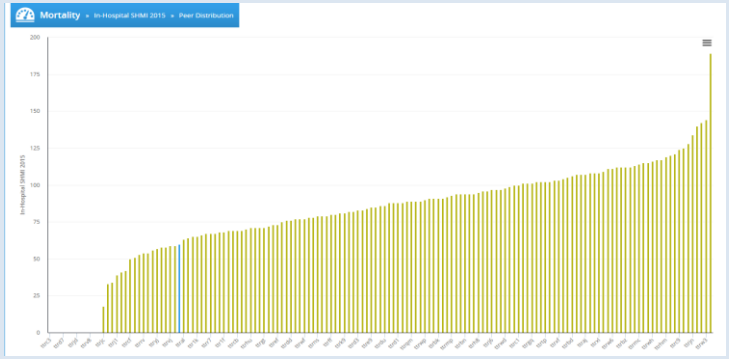
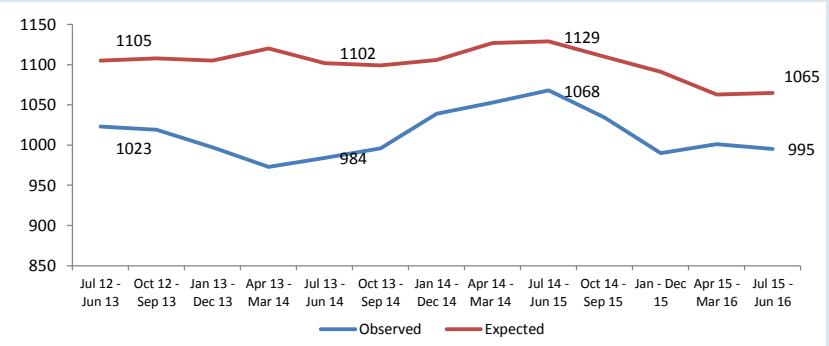
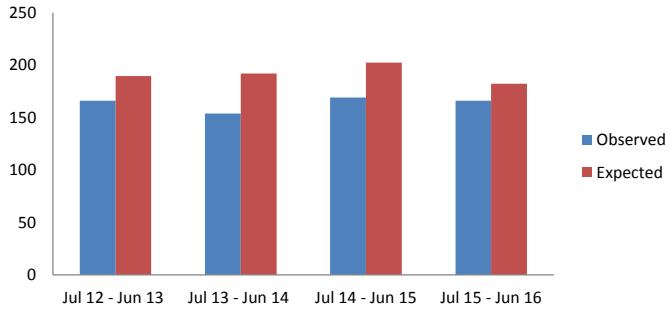
	Description	Aggregate Position	Trend/ Special Process Control: April 2015 →	Variation
Crude Mortality	Crude mortality rate shows the number of deaths per 100 hospital episodes of care from admission to discharge (spell).	Crude mortality is consistently below the national rate for all providers. Peer benchmarking is 3 months in arrears. December 2016 rate is **1.48%** of all episodes of care (latest available from CHKS). The rate is on the upper control limit which is set at three standard deviations from the average for the period of **1.05%**		There are no long-term alerts for groups for this time period; all show a stable mortality rate. Short-term variance is managed through the Delivery Assurance Groups and overseen by the Mortality Surveillance Group. In December 2016 there were **77** deaths. Of these there was **1** planned admission: CCS group: cancer of stomach. **12** of these deaths occurred within two days of admission. **3** deaths were attributed to **T+O,** primary diagnosis fracture of neck of femur. No maternal or paediatric deaths were recorded. **2** deaths had a learning disability secondary diagnosis; primary diagnosis for each COPD.
Hospital- Summary Hospital level Mortality Indicator [SHMI]	Ratio of the actual number of in-hospital deaths with what would be expected on the basis of average England figures for 140 diagnosis groups, given the characteristics of the patients treated (risk adjusted).	The in hospital SHMI compares favourably with peers with performance in the upper quartile of providers [April 2015 to date].		This indicator is not broken down to group level.
SHMI 30 days	The ratio of actual deaths and the number expected to die within 30 days of discharge from hospital on the basis of average England figures, given the characteristics of the patients treated. The indicator is updated quarterly and based on a rolling one year and released six months in arrears.	The SHMI ratio for July 2015 to June 2016 is 2015 is **0.93**. Values below one suggest a lower than expected number of deaths. A method of banding or control limit is used to help decide if a SHMI ratio exceeds expected limits. The Trust is banded as expected.		There are currently no mortality alerts. See over for the diagnosis groups with the highest number of deaths.

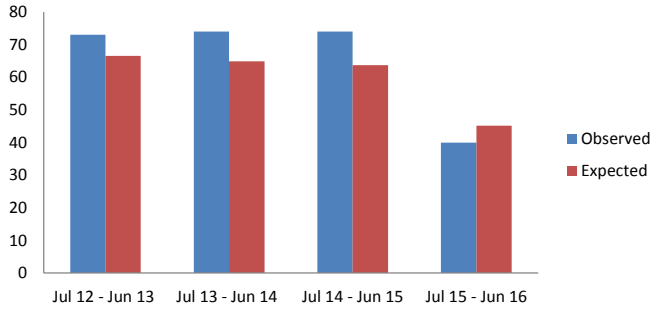
SHMI: top 5 diagnosis groups with highest number of deaths July 2015 — June 2016

The following diagnosis groups account for 34% of the 995 deaths that occurred in the above period. Where deaths are greater than expected, it should be noted that this does not necessarily mean that these are avoidable deaths. As illustrated below, the expected is re-calibrated and the risk model for doing this should be factored into any appraisal.

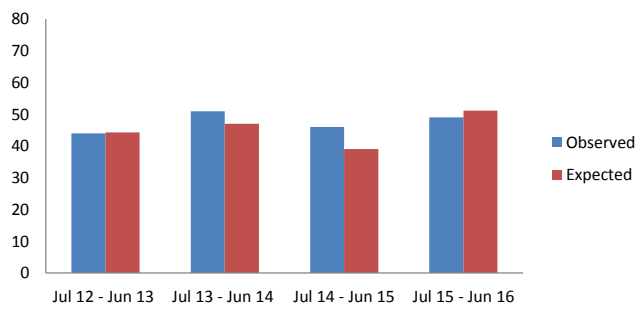
1. Pneumonia



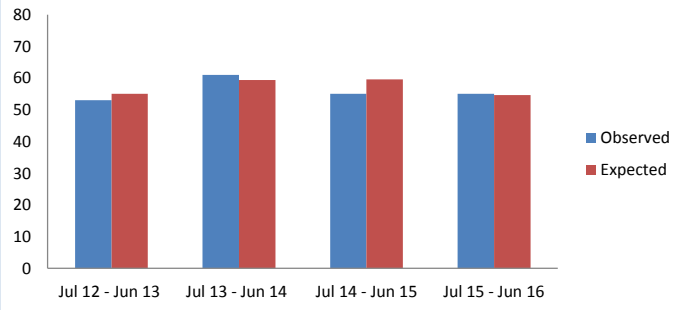
2. Acute cerebrovascular



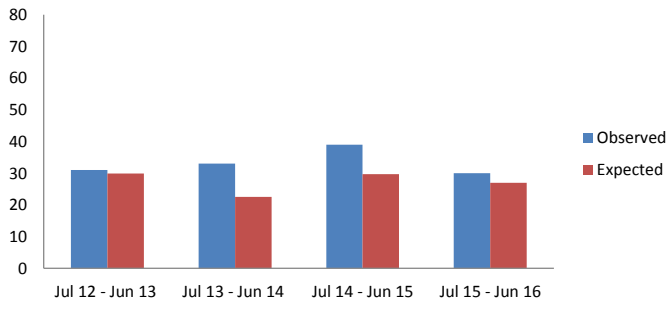
3. Congestive heart failure



4. Urinary tract infection



5. Fracture neck of femur



Mortality Surveillance Group - risk reduction plans:

A Fracture Neck of Femur Steering Group has been established to look at this and other information. The clerking proforma has been re-designed to ensure co-morbidities are accurate and complete. Provision of weekend physiotherapy is being considered alongside a protected single bed on Ward 9.

Acute cerebrovascular disease: since August 2015, a single site hyper acute unit for the first 48 to 72 hours of care is located at Bradford Royal Infirmary with Airedale's Ward 5 focusing on acute stroke care and rehabilitation. As illustrated, the change in the process of care has had an impact on the risk profile of the patient group and observed mortality.