From the top table ...

Peter Dyer, Medical Director of University Hospitals of Morecambe Bay (UHMB), discusses the importance of the coding process in defining the Trust's performance. Tony Halsall, Chief Executive of UHMB, comments on some of the other challenges facing the Trust.

Mortality indices: the importance of coding

Coding is the process by which the Trust obtains details about the diagnosis, treatment and outcome for our patients. It helps us to plan future services and is also the way by which we are currently funded. Accuracy is essential. Good coding relies on the skill of our clinical coders and their relationship with clinical colleagues. Mortality data is also collected and coded by the Trust.

This mortality data is used to inform two indices which are published annually. The first is collated by CHKS and is known as the Risk Adjusted Mortality Index (RAMI). The second is

the Hospital Standardised Mortality Ratio (HSMR), which is produced by Dr Foster and is published in their Hospital Guide.

The calculation of these figures is different for each index and results in scores which, although not hugely different, can be misleading. The Department of Health has, therefore, introduced a new mortality index this year (based on the information for 2010-2011) and which, because of a significant change in methodology, should produce a figure for mortality that has the confidence of staff and public. This indicator will be known as the Summary-level Hospital Mortality Indicator (SHMI) and will be published in the autumn of 2011. It is expected that one of the important differences will be the way in which palliative care coding and deaths after discharge from hospital are dealt with in the statistical method.

CHKS 'The leading provider of healthcare intelligence and quality improvement services'

The Trust has worked with CHKS for more than six years and has developed a good working relationship with this healthcare intelligence organisation. CHKS provides for the Trust a comprehensive dataset regarding the activities of each division, specialty and individual consultant. This information is available to all clinicians and managers and can be used to inform appraisal discussions.

One important aspect of CHKS's methodology is that the data can be adjusted in line with new coding information. Since June 2011, this adjustment has taken place weekly, ensuring that there is an accurate and current set of information. CHKS provides an annual report based on the latest data, but it is recognised that this can change even after the report has been produced.

The most recent annual report covers the period of April 2010 to March 2011.⁽¹⁾ It uses the *Insight* programme that places the Trust within a selected peer group to allow comparison of performance. CHKS has commented that the Trust treated a higher volume of patients in the 65+ age bands compared to the peer group and that not unexpectedly more patients died within these bands.

Dr Foster and the Hospital Guide

Although Dr Foster uses the same information from our coding, they select a basket of 56 diagnostic groups to determine the HSMR. Their report also gives details about how the Trust is performing with respect to stroke care, acute myocardial infarction, non-elective and elective orthopaedic surgery and discharges occurring at weekends.

PALLIATIVE CARE AND CODING

Connecting for Health has clarified the arrangements regarding the coding of patients admitted for palliative care.⁽²⁾ There are two main categories for end-of-life care coded 'Specialised Palliative Care' ICD-10, Z51.5 and 'Generalised Palliative Care' ICD-10, Z51.8.

Those patients coded as Z51.5 are not included in the overall mortality data of a trust whereas those patients coded Z51.8 are included in the final figure. This has led to allegations of data manipulation, whereby some trusts seek to minimise adverse publicity by using the code Z51.5 that excludes patients from mortality statistics. Whilst these allegations cannot be substantiated, it is hoped that the new SHMI will remove any doubts about the methodologies.

Conversely, patients with terminal illnesses entered onto an established, and widely accepted, pathway of good practice known as the Liverpool Care Pathway are coded Z51.8 and included in the overall mortality figure. There is thus a paradox, that where such a pathway is being used, as it is within this Trust, mortality figures will reflect this fact.

CAN WE IMPROVE OUR CODING, AND BY SO DOING INCREASE THE ACCURACY OF OUR MORTALITY STATISTICS?

Without good relations between coders and clinicians we will never produce accurate data. One good example of this in action relates to palliative care. Having identified that we had

coding difficulties in this area, clinicians and coders have now implemented an easy way for patients to be correctly identified. This has already improved our data. Although there is concern about the effect that coding may have on the mortality rates, it is known from the experience of other trusts that improved relations between coders and clinicians will also ensure better coding for all admissions.

We have developed a template document which is created each time a death is coded and which is sent to the last-named consultant. The consultant is asked to confirm the diagnosis and cause of death, as well as confirming individual responsibility for the patient. This template can now be returned by email.

Dr Peter Nightingale, the lead general practitioner for end-of-life care in the district has recently introduced a system for patients to have an 'Advanced Directive' in place if they are being managed in the community. It is hoped that this will lead to fewer patients being admitted to die in hospital. The prospect of such information being available on the Lorenzo system as an automated 'alert' message is currently under discussion.

MORTALITY: TRUE FIGURES OR STATISTICAL ANOMALIES?

Coding can only help to address important clinical issues if it has the confidence of the staff that it is accurate.

The monthly mortality figures sent to the executive and the associate medical directors are discussed on a monthly basis. The divisions review the data at their governance meetings and look at those cases where the patient was judged to have been a low risk of mortality (less than 20%) at the time of admission. Individual cases, so identified, can be reviewed with clinical staff. We have recently arranged for this information to be reported to the Clinical Quality and Safety committee chaired by a non-executive director and thus the Board. Involvement of the most senior tier of Trust management in this way is our way of ensuring that we will continue to deliver high standards of health care to our community.

REFERENCES

1. *Insight Summary Report.* CHKS Mortality April 2010 to March 2011. June 2011
2. *Palliative and End of Life Care.* Coding Clinic. Connecting for Health. Volume 7 Issue 4. June 2010

Peter Dyer
Medical Director

Challenges facing the Trust

As you will be aware, over the past two months, we have been under intense scrutiny from our regulators, the press and the public.

The three key issues which have raised concerns are:

- Maternity services
- Outpatient follow up
- Hospital mortality statistics.

The Trust Board's primary concern is that we deliver safe, effective services to all our patients. The directors and staff across all our hospitals are focused on accelerating the pace of change needed to ensure that we are delivering the highest standard of care possible to all our patients across Morecambe Bay, at all times.

MATERNITY SERVICES

In September, the Care Quality Commission (CQC) published its Review of Compliance into our maternity services across the Bay which stated that we failed to meet six of the essential standards and detailed improvements that have to be made by 21 November 2011. It then issued us with a formal Warning Notice regarding our maternity services.

As a consequence of the CQC review, Monitor, the independent regulator of NHS Foundation Trusts (FTs), increased our governance risk rating to red and subsequently announced that we are in significant breach of the terms of our authorisation and it has used its formal powers of intervention to require action.

In the main we know our hospitals offer a very high quality and safe level of service and many women have come forward to share their positive stories and offer supportive messages with our maternity staff. Nevertheless we are disappointed that the CQC found any concerns. We know this is not acceptable and making improvements is now a top priority.

Since receiving the CQC's report, we have completed the majority of the actions required and are confident that we will do all we can to resolve the remaining issues. We have invited a high-level team of clinicians to come in and work collaboratively with and support our staff in a number of areas, including obstetrics, gynaecology, paediatrics and midwifery. By bringing in this team of specialists, we will ensure that we continue to improve our maternity services and that safe, effective care continues to be delivered to all our women, both now and in the future.

We have also now agreed the terms of reference with Monitor for their expert clinical diagnostic advisors who will be coming into the Trust to pull together a simple risk log and action plan incorporating all previous work, reports and action plans into one place.

There are longer-term plans to develop a partnership relationship with Liverpool Women's NHS Foundation Trust to provide mentorship, support and to further develop clinical leadership for our services for women and children.

OUTPATIENT FOLLOW-UP APPOINTMENTS

You will also be aware that we have some problems with our outpatient appointment system which could have resulted in follow-up appointments having been delayed.

It is very disappointing that this problem occurred and we regret the fact that it will have caused concerns among patients. In order to make sure that anyone who has been affected is given an appointment as soon as possible a team, which includes clinicians, is working to establish the number and nature of appointments that may have been delayed. If delays are identified, individual patients will be contacted to make a new appointment. However, if patients have immediate concerns about their follow-up appointment they can call a 24-hour, seven days a week, dedicated phone line on 0845 608 0278.

HOSPITAL MORTALITY STATISTICS

I am grateful to Peter Dyer for his accompanying article describing the way in which mortality data is collated. Suffice to say that the new statistical method, the Summary-level Hospital Mortality Indicator (SHMI), shows different results from the Dr Foster data. The media has reported the increase in the Dr Foster measured mortality even though the final score won't be officially released till the end of November and despite our own observations that the actual number of deaths has remained unchanged year on year.

We were recently made aware that our Dr Foster score would increase this year, although the increase is not in line with the actual number of deaths which has remained consistent year on year. The media reported the increase in the Dr Foster data even though the final scores have not yet been finalised and will not be published until the end of November. The SHMI statistics have also been in the media and these are not consistent with the Dr Foster data.

We are taking a close look at the data to ensure that we understand the increase in the Dr Foster score. Once the data issues have been resolved we understand that this will be reflected in our score.

CONCLUSION

We are not complacent about any of these issues. The actions we are now taking are just the start of our improvement journey. What we need to do is focus our attention on enhancing patient safety in the longer term and we will continue to work hard to take rapid and effective action.

Over the past few months, we have received some tremendous support from clinicians and administration staff and I would like to take this opportunity to sincerely thank them for all they have done.

Tony Halsall
Chief Executive