



## **Section 41 – information provided in confidence**

I consider that some of the information provided at the event contains information that is exempt under section 41 of the FOI Act. Section 41(1) provides that information is exempt information if:

“(a) it was obtained by the public authority from any other person (including another public authority); and

(b) the disclosure of the information to the public (otherwise than under this Act) by the public authority holding it would constitute a breach of confidence actionable by that or any other person.”

The test in section 41(1)(a) is met as the information was obtained by the TDA from a third party.

The test in section 41(1)(b) is met if disclosure would amount to an actionable breach of confidence. This means:

- (i) the information must have the necessary quality of confidence about it;
- (ii) the information must have been imparted in circumstances giving rise to an obligation of confidence;
- (iii) disclosure must amount to an unauthorised use of the information to the detriment of the person providing it.

Monitor considers that disclosure of the information being withheld would amount to an actionable breach of confidence. The information is not in the public domain and was subject to an express duty of confidentiality owed to the provider. It was then made available to an invited audience at the event on the basis that it would not be subject to further dissemination. It therefore has the necessary quality of confidence.

Section 41 is an absolute exemption and does not require the application of the public interest test under section 2(2) of the FOI Act. However, in considering whether (in an action for breach of confidence) a confidence should be upheld, a court will have regard to whether the public interest lies in favour of disclosure. Where a duty of confidence exists, there is a strong public interest in favour of maintaining that confidence. Whilst the information could quite properly be said to be a matter of public interest, there is a considerable amount of information on mortality already in the public domain. Monitor has also decided to release further information in response to your request: that information is attached.. It follows that, in the present case, I considers that the strong public interest in maintaining confidentiality outweighs the public interest in disclosure.

## **Review rights**

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an

internal review within Monitor of the issue or the decision. A senior member of Monitor's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review conducted by Monitor, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, Monitor, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to [foi@monitor.gov.uk](mailto:foi@monitor.gov.uk).

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Stanley Silverman', with a long horizontal flourish extending to the right.

**Stanley Silverman**  
Deputy Medical Director

## Annex

<b>Document</b>	<b>Page of document</b>	<b>Decision</b>	<b>Exemption</b>
<b>Email to attendees</b>		Disclosed	
<b>National Mortality Learning Community event 17 July 2015 slide pack</b>		Disclosed save for page redactions listed below.	
	13	Redacted	s.41
	14	Redacted	s.41
	16	Redacted	s.41
	67	Redacted in part	s.41
	71	Redacted in part	s.41

Dear Colleagues,

### **National Mortality Learning Community**

Thank you for attending the inaugural National Mortality Learning Community event which took place on Friday 17<sup>th</sup> July. As agreed we have attached a copy of the presentation slides from the event.

There was a healthy discussion at the event and the feedback highlighted how helpful colleagues found it to network; share learning; and to discuss experiences and ideas for quality improvement. We also had positive feedback about the presentations from organisations that have achieved improvements in quality.

Reflecting on the feedback it was clear that colleagues would appreciate the opportunity to continue to share learning through a virtual platform. We are therefore planning to facilitate webinar sessions on specific topics or issues and to record so that they can be accessed freely.

It was also clear that colleagues would appreciate further networking meetings or events and we will therefore reflect on how best to facilitate these regionally and/or nationally.

If you have any further reflections which you would like to share please do not hesitate to get in touch via [email](#).

With best wishes,

Kathy McLean  
**NHS TDA Medical Director**

Stan Silverman  
**Monitor Deputy Medical Director**

# National Mortality Learning Community

Friday 17<sup>th</sup> July 2015

Kathy McLean, NHS Trust Development Authority Medical Director  
Stan Silverman, Monitor Deputy Medical Director

# **INTRODUCTIONS, SCENE SETTING AND NATIONAL PERSPECTIVE**

# Agenda

Time	Topic	Lead/s
09:30 – 10:00	Registration, Tea and Coffee	
10:00 – 10:10	Introductions, scene setting and national perspective	Kathy McLean, TDA MD Stan Silverman, Monitor Deputy MD
10:10 – 10:30	Measuring mortality – what does it mean?	Richard Wilson, TDA Quality Intelligence and Insight Director
10:30 – 11:00	Lessons learned and making the improvement	David Fillingham, Chief Executive Andrea McGuinness, Safety Programme Lead Advancing Quality Alliance (AQuA)
11:00 – 11:30	George Eliot Hospital NHS Trust	Gordon Wood, Medical Director James Avery, Head of Patient Safety & Mortality
11:30 – 12:00	Mid Cheshire Hospitals NHS Foundation Trust	Dr Paul Dodds, Medical Director Mrs Julie Smith, Director of Nursing and Quality
12:00 – 12:30	Panel discussion and reflections	All
12:30 – 13:30	Lunch and networking	
13:30 – 14:15	Working groups – deeper dive into driver diagrams	All
14:15 – 14:30	Feedback and reflection	All
14:30 – 15:15	Working groups – building a driver diagram for your trust	All
15:15 – 15:30	Feedback and reflection	All
15:30 – 16:00	Developing a mortality learning community – open discussion	Kathy McLean, TDA MD Stan Silverman, Monitor Deputy MD
16:00	Close	

Richard Wilson, NHS TDA Quality Intelligence and Insight Director

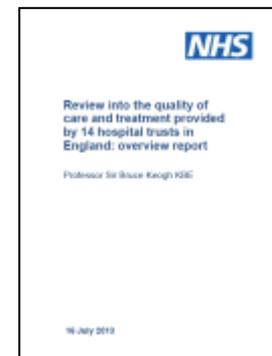
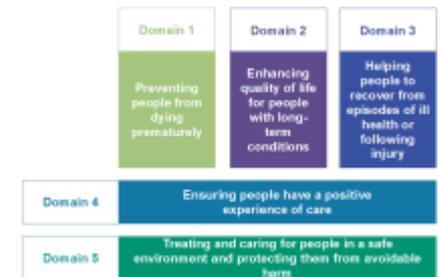
# **MEASURING MORTALITY – WHAT DOES IT MEAN?**

# Summary

- What is mortality and why is it important
- How we measure it in the NHS

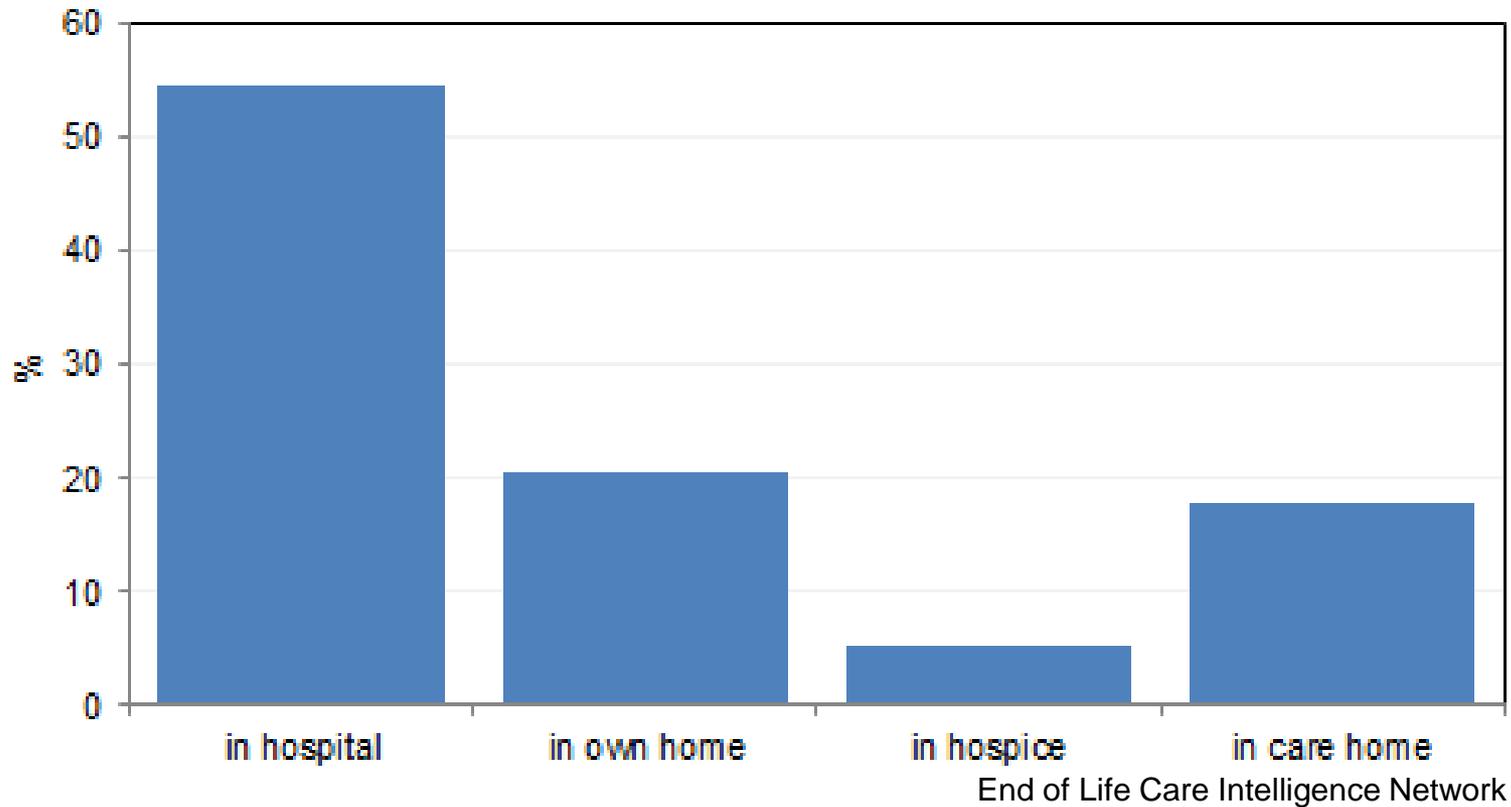
# Mortality

- HSMR was introduced by Prof Jarman in 2001 and has been published ever since annually by Doctor Foster Intelligence
- Came to national prominence with the Mid Staffs and the Francis Inquiry
- Hospital Mortality was included in the Outcomes Framework by NHS England
- And was the focus of the Keogh Review of 14 Trusts in 2013



# Most people die in hospital, but this is declining

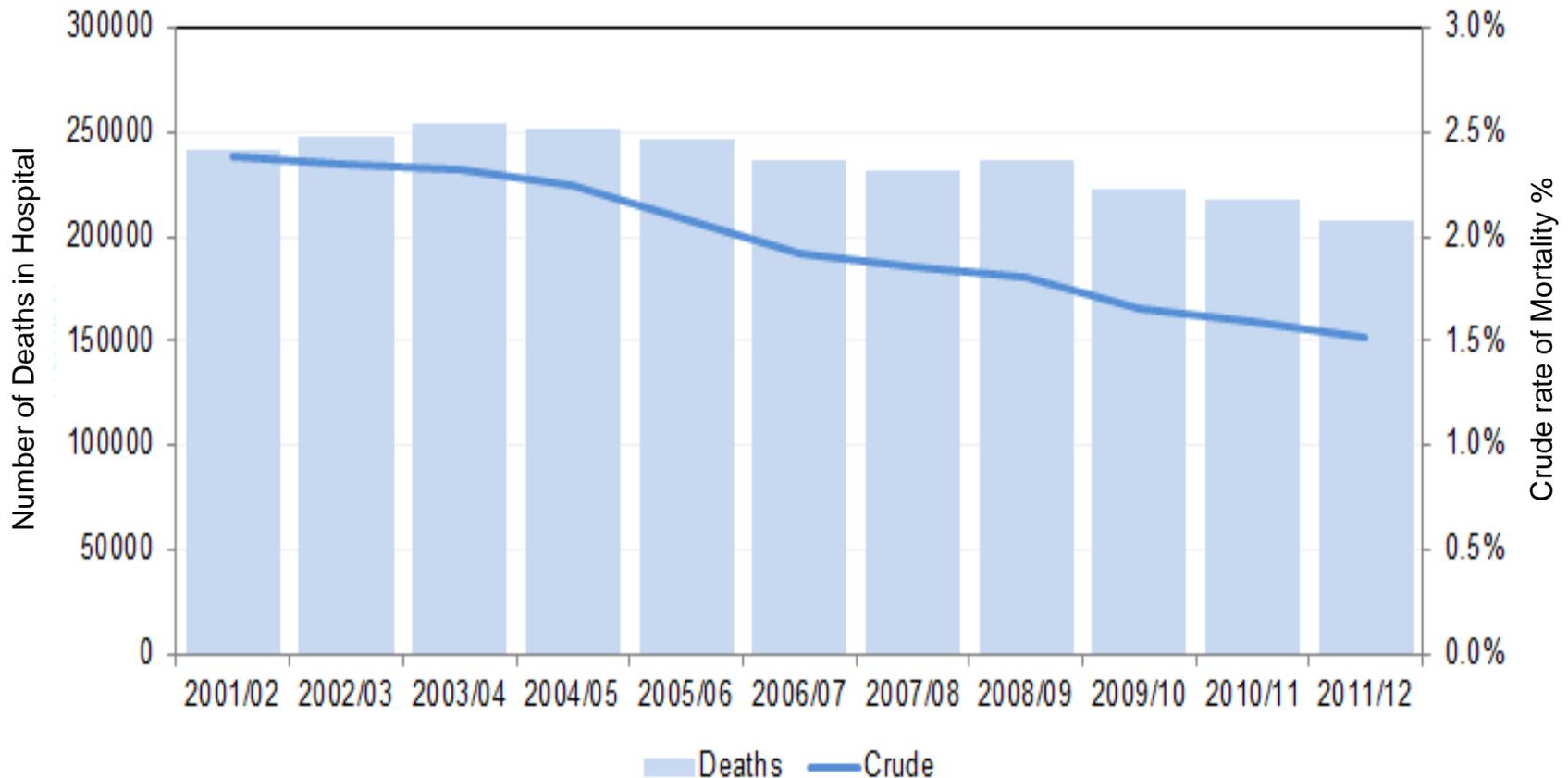
% Deaths by Place of death  
2008-10



# Hospital mortality is falling in England:

improvement in care or related to choices about where people die?

**Hospital Deaths and Crude mortality**  
2001/2 to 2011/12



# Mortality

- Two major methodologies in use:
  - Crude mortality
  - Casemix adjusted measures ( Standardised mortality)
- Each provides a different list of ‘outliers’
- No consensus on which is more informative
- No evidence available on their reliability to predict avoidable mortality

*“demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies.” (Robert Francis, 2013)*

## Standardised measures

There are 3 main standardised mortality rates in use by the NHS:

- a) **Summary Hospital-level mortality indicator (SHMI)** an annual figure published quarterly by Health and Social Care Information Centre (HSCIC), latest published figure Oct 2013 to Sep 2014
- b) **Hospital Standardised Mortality Ratio (HSMR)** annual figure published annually by Doctor Foster Intelligence (DFI) and monthly to subscribers, latest published figure Apr 2012 to Mar 2013
- c) **Risk Adjusted Mortality Index (RAMI)** annually figure produced monthly to subscribers, no published figures

Other information companies re-calculate HSMR using the published DFI methodology, including Healthcare Evaluation Data who the TDA and NHSE have a contracts with. TDA also has a licence with DFI for quarterly remodelled HSMR.

## 5a\* Deaths in hospital from problems in care

- NHS E are in the process of developing this indicator based on retrospective case record reviews
- This work is being lead by Professor Nick Black at the London School of Hygiene and Tropical Medicine
- Approach has been identified as the most sensitive for assessing overall **avoidable** (death?) harm in care
- The estimate from the pilot work (1) is that there are 12,000 avoidable deaths in English Hospitals and this was used to set the objective for '*Sign up to Safety*'

\* Previously 5c

1 - Hogan et al: *Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study*

# How do I Interpret them?

Simply

- **More than 100.** Trust mortality rate is higher than average
- **Less than 100.** Trust mortality rate is lower than average

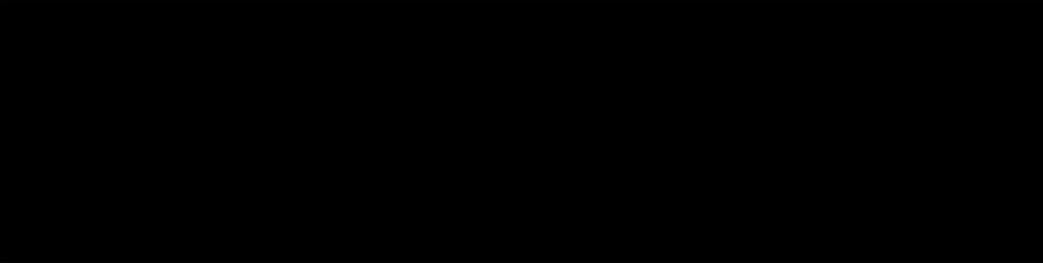
N.B. for SHMI this is around 1

However, it's not simple! Need to consider

- Imprecision in statistical models
- Using confidence intervals
- Different statistical methodologies

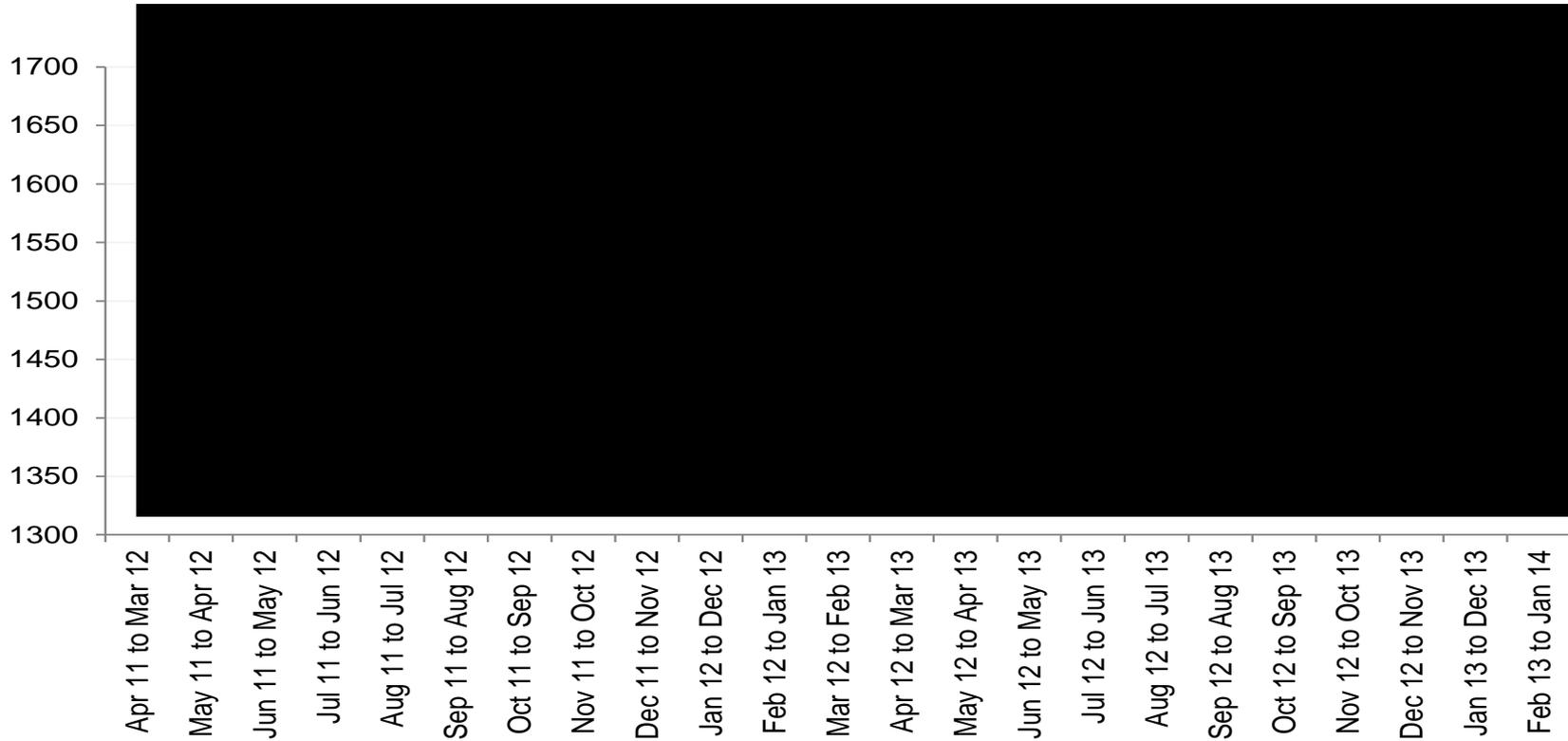
# Confidence intervals

*confidence interval* is an statistical estimate based on the assumptions about a normal population. A confidence interval contains an initial estimate plus or minus a *margin of error* (the amount by which you expect your results to vary, if a different sample were taken).



N.B. overlapping confidence limits suggest no significant difference

# What influences your mortality ratio?



- **Observed values** influenced by quality of care and place of death
- **Expected values** influenced by characteristics of the population, emergency vs. elective admission; age of patient; gender; diagnosis and co-morbidities; palliative care; deprivation;

# Key differences between HSMR and SHMI

HSMR	SHMI
Deaths in 56 diagnosis groups which contribute to approx. 80% of in hospital deaths	All deaths in hospital and those outside within 30 days of discharge
Adjustments for <ul style="list-style-type: none"> <li>▪ Month of admission</li> <li>▪ Socio economic deprivation</li> <li>▪ Palliative care</li> </ul>	
Reported around 100	Reported around 1
Two statistics: Standard – uses the last year as average Remodelled - based under current national average	Always based around the national average

# What do most people die from in hospital?

Top 20 numbers of deaths by diagnosis



# Not all deaths are avoidable

Often, the inference is that if observed death rates in a hospital exceed those expected, then the gap is due to quality problems.

However for an average DGH with **28,000** discharges a year

- There is likely to be a death occurring in 5% to 10% of all hospitalised patients, resulting in approximately **1,400 to 2,800 deaths**
- Of these it is estimate that 5% of deaths are avoidable **70 to 140 deaths**

To note:

- **Most quality problems do not cause death, although they may result in injury, complications and prolonged hospital stays**
- **In the absence of detailed review of clinical case records, avoidable deaths cannot be distinguished from inevitable deaths**

## Understanding Points to take away

- Measures differ, although are similar
- Calculates number of 'Expected deaths' there would be if the hospital had the national death rates by age, sex, elective/non-elective, diagnosis, etc
- Excess deaths (O-E)  $\neq$  clinically avoidable deaths
- Expected deaths  $\neq$  clinically expected deaths
- About 25% of HSMRs could be high by chance.

## **But why considering mortality rates is also tricky...**

- High mortality rates don't necessarily mean poor quality care
- Standardised mortality rates have a number of methodological problems and "noise in the data"
- It's difficult to use mortality rates to compare one hospital with another
- Hospital mortality rates are an average across specialities... It's important to have a service specific understanding
- Giving an accurate and balanced message to local partners, regulators, and the public and the media is vital

## Why it's essential to consider mortality rates carefully...

- Patients and families are rightly concerned about them ... we all would be!
- They can be a “smoke alarm” giving early warning of problems
- Even the best hospitals will have some avoidable deaths
- Efforts to improve mortality rates have a wider beneficial impact on general quality of care

David Fillingham

Chief Executive, Advancing Quality Alliance (AQuA)

# LESSONS LEARNED AND MAKING THE IMPROVEMENT

# Mortality Rates

**How to use them to improve the quality of care**

David Fillingham



**Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report**

Professor Sir Bruce Keogh KBE

16 July 2013

**A promise to learn  
– a commitment to act**

**Improving the Safety of Patients  
in England**

National Advisory Group on the  
Safety of Patients in England

August 2013

THE MID-STAFFORDSHIRE  
NHS FOUNDATION TRUST  
PUBLIC INQUIRY

Chaired by Robert Francis QC

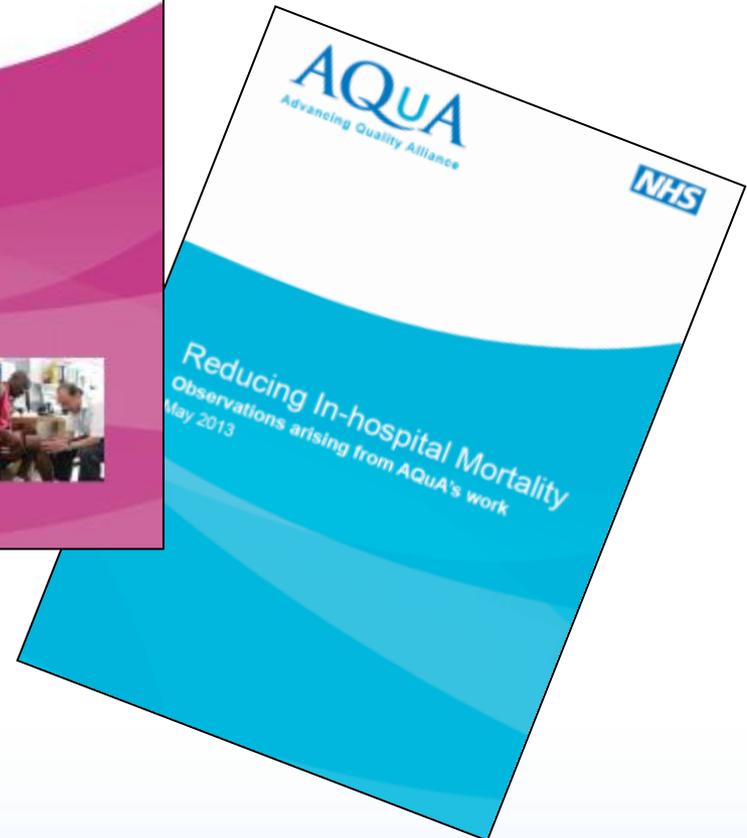
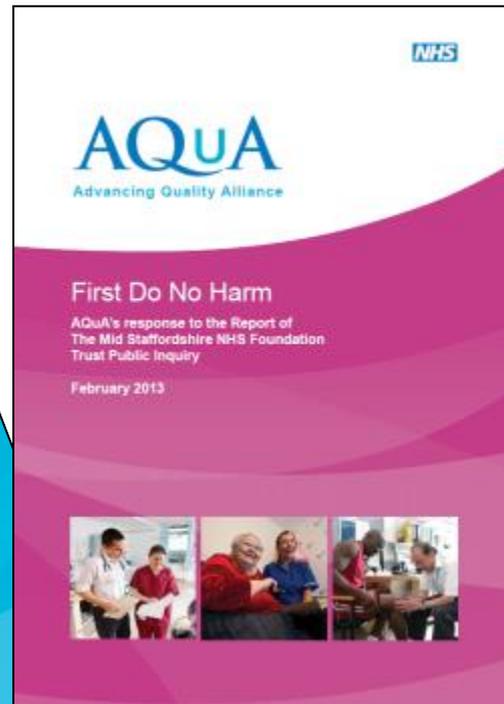
**Report of  
the Mid Staffordshire  
NHS Foundation Trust  
Public Inquiry  
Executive summary**

HC 987

- About AQUA
- What influences mortality rates?
- Developing a driver diagram
- Emerging themes
  - Reliability
  - Patient flow
  - Safety
- An example: Aintree NHS FT

# About AQuA

- A regional quality improvement organisation for the NHS in the North West
- Established in 2010
- Funded on a membership fee basis by 72 organisations (CCGs and providers)
- Works with a wide range of partners locally, regionally and nationally
- Safety and Mortality are a major focus of our work



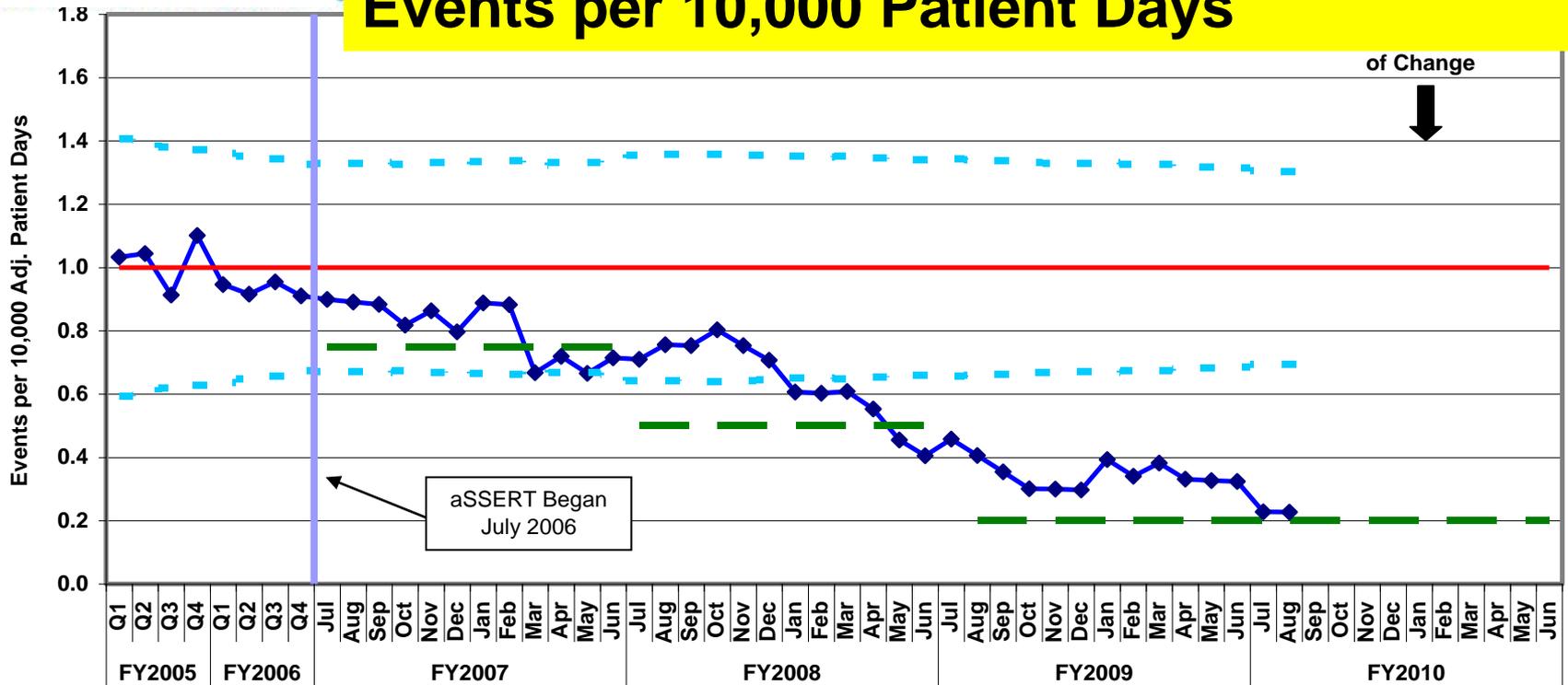
# Our work to date

- First Mortality collaborative (2010/11)
- “Deep Dive” reviews in six organisations
- Quarterly Mortality report
- Second Mortality collaborative (2014/15)
- Review of regional variations in SHMI
- Links to our work on safety, reliability , integration, patient experience and building improvement capability

# Putting a face on the data

- Mortality data can be reduced to “dry statistics”
- At the other extreme they can be misinterpreted in highly emotive and damaging ways
- It’s vital to have a clear evidence based view
- At the same time we must always be aware of the human cost: “ put the patient in the room”

# Aim: Reduce harm to children by 80% in 3 years, as measured by Serious Safety Events per 10,000 Patient Days



\*\* Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months ( $p=0.05$ ).

\*\* The narrowing thresholds in FY2005-FY2007 reflect increasing census. Adjusted patient days for FY07 were 27% higher than for FY05.

- ◆ SSEs per 10,000 Adj. Patient Days
- Baseline [ 1.0 (FY05-06) ]
- Fiscal Year Goals (FY07=0.75 / FY08=0.50 / FY09=0.20)
- Threshold for Significant Change

**John B.**  
9/06/2008  
Advanced Safety Alliance

Delay in Dx

**Shirley H.**  
12/23/08

Post Proced Death

**Florita H.**  
7/03/2008

Delay in Tx

**Wade W.**  
7/16/2008

Delay in Tx

**Baby Boy S.**  
8/1/2008

Wrong Pt. Procedure

**Joseph R.**  
9/08/2008

Delay in Dx.

**Tamika M**  
4/21/2008  
Med Error

**Andrea M.**  
6/24/2008

Wrong Procedure

**Nancy H.**  
6/18/2008

Med Error

**Jimmy P.**  
7/07/2008  
Fall

**Joann E.**  
9/23/2008  
Wrong Site Surgery

**Cynthia M.**  
10/27/2008  
Med Error

**Regina D.**  
12/9/2008  
Wrong Site Surgery

**Baby Girl V.**  
5/12/2008

Mother's Delay in Tx

**Kyle W.**  
9/13/2008  
Delay in Tx

**Teodur C.**  
1/29/08, 2/12/2008  
Delay in Tx

**Alvin G.**  
8/17/2008  
Fall

**Nicole S.**  
1/4/2008  
Delay in Dx

**Margaret H.**  
2/6/2008  
Med Error

**Ursula H.**  
2/12/2008  
Fall

**Ms. L.**  
2/14/2008  
Delay in Tx

**Sandra M.**  
12/10/2008  
Post Procedure Death

**Karen G.**  
8/5/2008  
Proced Cx/Delay in Tx

**Cynthia K.**  
11/10/2008  
Delay in Tx

**Lance D.**  
10/30/2008  
Delay in Tx

**Nicole H.**  
8/12/2008  
Post-proced Cx

**Robert S.**  
10/13/2008  
Fall

**Mary D.**  
3/9/2008  
Med Error

**Baby Boy G.**  
3/25/2008  
Med Error

**Lorena W.**  
11/10/2008  
Post Procedure Death

**Priscilla W.**  
8/30/2008  
Delay in Tx

**Dale W.**  
10/12/2008  
Med Error

**Eugene B.**  
10/27/2008, 10/28/2008  
Med Error, Fall

**Kathy W.**  
12/16/2008  
Post Proced Loss  
of Function

**Robert B.**  
12/2/2008  
Post Procedure Death

**Virginia L.**  
8/12/2008  
Delay in Tx

**Helene C.**  
9/5/2008  
Fall

**Lester J.**  
9/5/2008  
Fall



**Calvin P.**  
4/4/2008  
Med Error

**Gwendolyn P.**  
10/28/2008  
Wrong Implant

**Chantal E.**  
6/26/2008  
Inapprop Touching

**Gary B.**  
6/13/2008  
Fall

**Mary C.**  
12/19/2008  
Fall

**Douglas T.**  
10/18/2008  
Med Error

# 24 Patients & Events – Jan-Dec,2009 vs 46 Total for 2008



Advancing Quality Alliance



Louene D.  
9/23/09  
Fall

Beverly S.  
2/4/09  
Med Error

Robert D.  
5/12/09  
Post Procedure Death

Karen C.  
9/28/09  
Delay In Treatment

Peggy P.  
7/1/09  
Burn

Sharenda W.  
2/15/09  
Med Error

Edward R.  
4/23/09  
Wrong Side Procedure

Brenda R.  
10/14/09  
Delay In Treatment

James H.  
10/25/09  
Post Procedure Death

Lilliam C.  
4/3/09  
Retained foreign object

Dorothy R.  
1/28/09  
Delay In Treatment

**47% Reduction SSER from Dec. 08 Baseline  
48% Reduction in # of events year to year**

Donna S.  
6/4/09  
Retained foreign object

Monroe K.  
5/18/09  
Post Procedure Death

Jerry Y.  
11/7/09  
Fall

Yoland C.  
7/7/09  
Delay in Treatment

Scott G.  
9/5/09  
Delay in Treatment

Juanita A.  
5/14/09  
Delay In Treatment

Johnny B.  
11/9/09  
Fall

Alma M.  
11/6/09  
Fall

Ronnie D.  
11/3/09  
Delay in Treatment

Michael F.  
8/20/09  
Retained foreign object

Willie B.  
11/5/09  
Med Error

Pauline M.  
11/2/09  
Fall



Helen C.  
11/4/09  
Delay In Treatment

Lois R.  
4/16/10  
Surgical Fire

Mary B.  
5/22/10  
Post Procedure Cx

Lamar A.  
6/3/10  
Med Error

Bruce C.  
5/25/10  
Delay In Dx

Marilyn C.  
1/21/10  
Med Error

Sylvia L.  
3/31/10  
Delay In Dx

Ruby B.  
5/30/10  
Fall

Frank S.  
2/22/10  
Surgery Cx

Doyle L.  
7/22/10  
Med Error



What influences a hospital's  
mortality rate?

## **Important influences on a hospital's mortality rates**

- The make-up of the local population (age, gender, deprivation, disease prevalence)
- Deaths in hospitals versus own homes, care homes, hospices
- “Case-mix” (the types of patients treated)
- Overall systems of care: hospitals; GPs; community services; social care
- Safety and effectiveness of care delivered
- Safe staffing levels – on a 24/7 basis and staff engagement/motivation

## Quality and Safety in the NHS: Evaluating Progress, Problems and Promise

Michael West<sup>1</sup>, Richard Baker<sup>2</sup>, Jeremy Dawson<sup>3</sup>, Mary Dixon Woods<sup>2</sup>, Richard Lilford<sup>4</sup>,  
Graham Martin<sup>2</sup>, Lorna McKee<sup>5</sup>, Madeleine Murtagh<sup>2</sup>, Patricia Wilkie<sup>6</sup>

<sup>1</sup> Lancaster University

<sup>2</sup> University of Leicester

<sup>3</sup> University of Sheffield

<sup>4</sup> University of Birmingham

<sup>5</sup> University of Aberdeen

<sup>6</sup> National Association for Patient Participation

<sup>7</sup> Aston University

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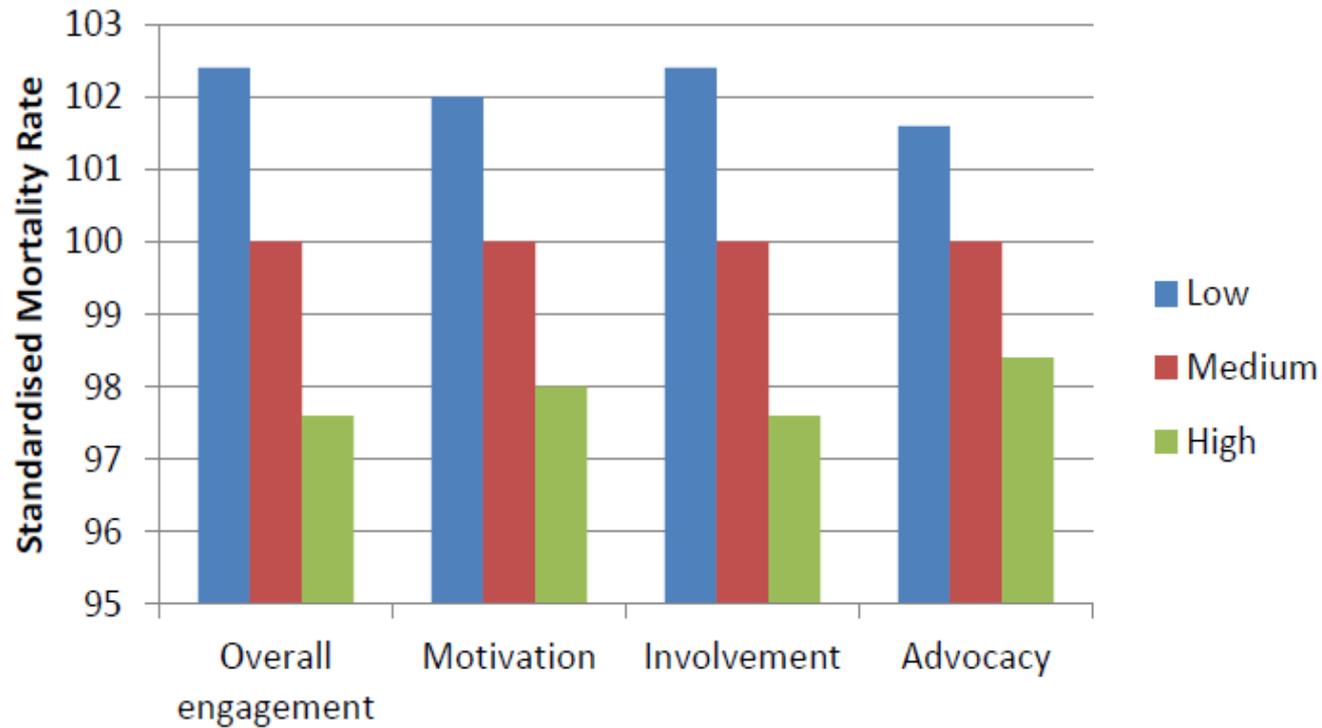
Website: [www.lums.lancs.ac.uk/nhs-quality](http://www.lums.lancs.ac.uk/nhs-quality)



Disclaimer: The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the Department of Health.

“Overall, the best predictor of a variety of outcomes including staff health and wellbeing, absenteeism, intention to quit, quality of patient care, patient mortality and use of resources **was the level of staff engagement .**” (M West et al)

### Patient Mortality by Engagement



# What Influences Standardised Mortality Rates?

- Everything that influences the crude rate

AND

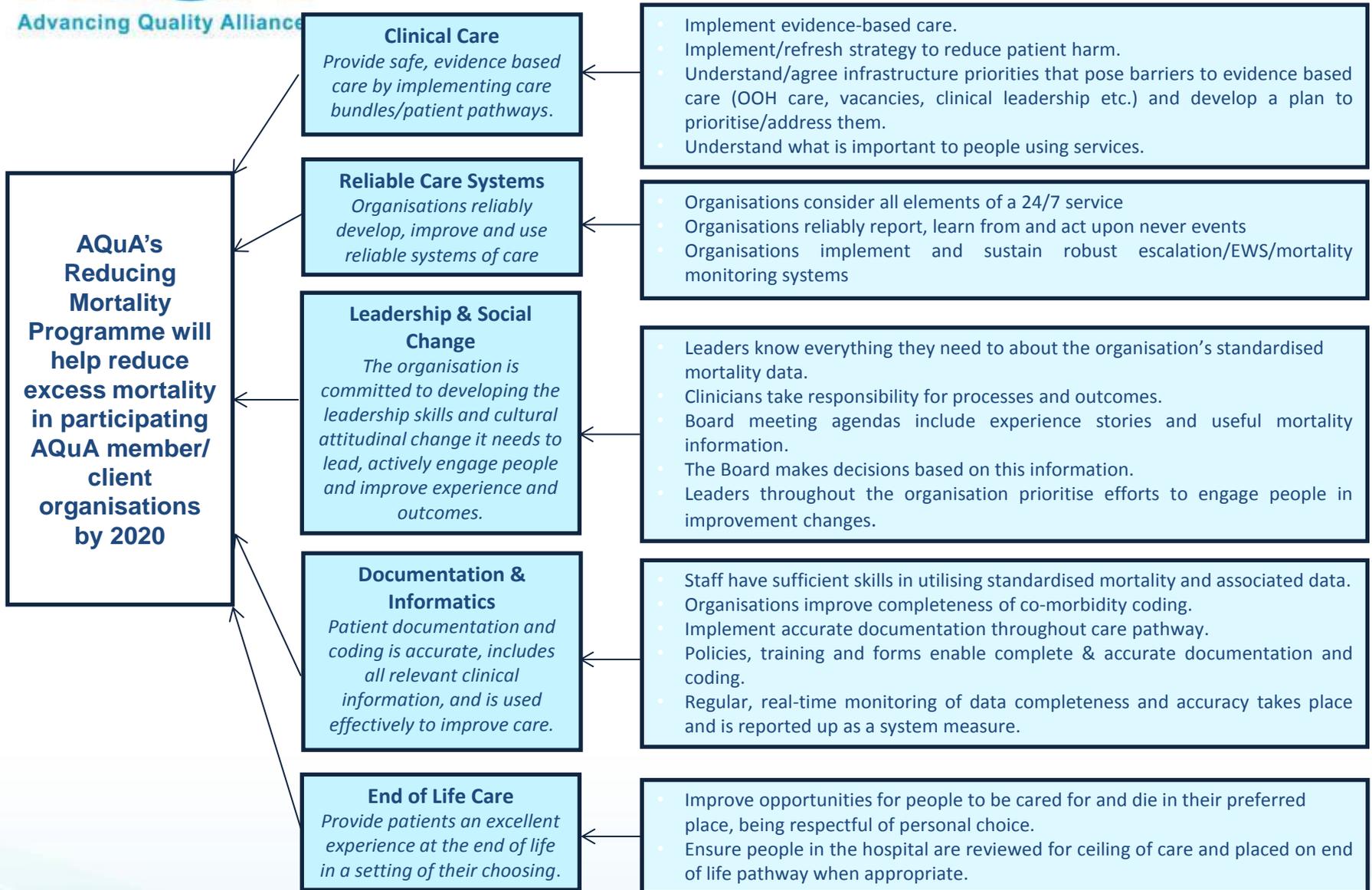
- the particular standardisation formula used (SHMI, HSMR, RAMI)
- the coding and recording of data
  - accuracy of first recorded diagnosis
  - capturing of “co-morbidities”
  - recording of palliative care

So... in assessing the Quality of Care provided, mortality rates can be an important “smoke alarm”. But they are just one part of the picture. What else should we be looking at?

## AQuA's Mortality Reviews – intelligence used

- Local Health Economy Data
  - health of population
  - deprivation
  - GP and other services
- Crude Rate
- SHMI/HSMR Standardised Rates
- Staffing Levels
- Incident Reporting
- Documentation
- Coding
- End of Life Care
- Complaints
- Healthcare Acquired Infections
- Safety Thermometer (falls, pressure ulcers, thrombosis, catheter acquired urinary infections)
- Patient survey
- Friends and Family test
- Staff survey
- Flow (A&E waits, length of stay, delayed discharges)
- Focus Groups with staff and observations

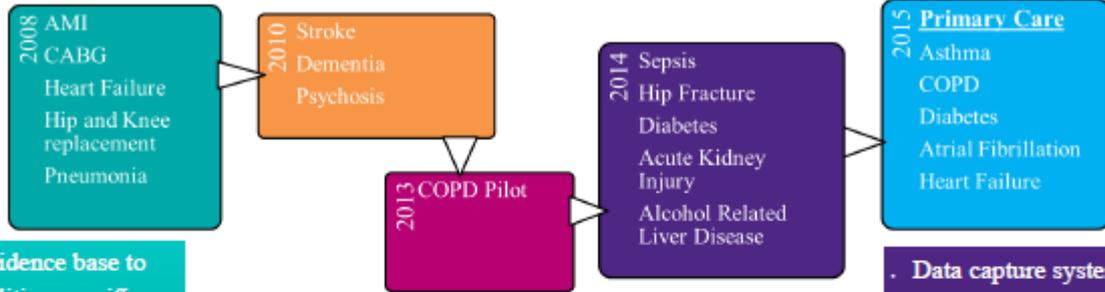
How can we improve the quality of care and seek to reduce mortality rates?



# Reliability

- Healthcare is poor at ensuring the reliability of key clinical processes that are essential to safety and effectiveness
- The Advancing Quality programme has increased compliance with evidence based care bundles in 14 conditions in 26 hospitals in the North West

# Method



AQ measures compliance with each clinical process measure that each patient is clinically eligible to receive.

Clinical Expert Groups review evidence base to determine a small number of condition specific interventions, known to improve patient outcomes - known as 'AQ measures'. Eg -

- Heart Failure: evaluation of Left Ventricular Systolic Function; ACEI or ARB prescribed at discharge
- Hip & Knee Replacement: correct antibiotic selection; timely antibiotic administration.

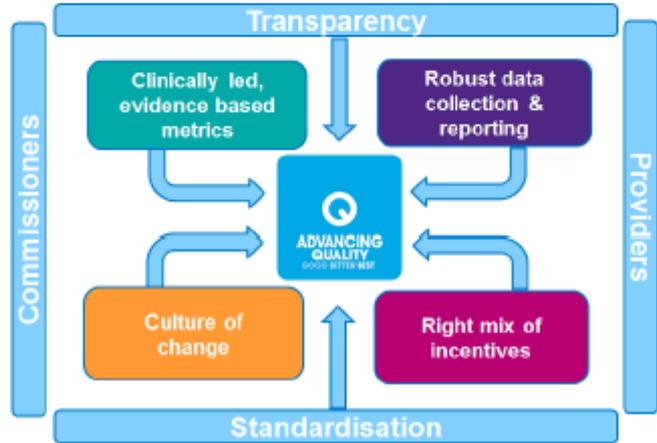
- Shared values & positive culture of change.
- Teams share ideas and best practice.
- Regular pan-region learning and networking events.



- Data capture systems developed and data for every patient admitted to a North West hospital (in an AQ condition) is captured.
- Data assurance framework ensures high quality data capture.
- Transparent reporting - teams see how others are performing, benchmark their own practice and identify opportunities to improve.

Incentive framework designed to appeal to different audiences:

- Pay for Performance and CQUINs.
- Public reporting.
- Transparent data.
- Improvement targets.
- "Doing the right thing".



**Alcohol Related Liver Disease: Key Facts**

- 1 in 4 adults drink in a way that is potentially harmful
- Speeds up liver disease
- 300,000 people in the UK have liver disease
- £3.5 billion a year spent on alcohol
- North West has the highest alcohol consumption in the UK
- Early identification is key

**Diabetes: Key Facts**

- 1 in 10 people in the UK have diabetes
- Diabetes is the 6th leading cause of death in the UK
- 1.1 million people in the UK have diabetes
- 1 in 10 people in the UK have diabetes
- 1 in 10 people in the UK have diabetes

**Hip Fracture: Key Facts**

- 20% of people in the UK have a hip fracture
- 1 in 10 people in the UK have a hip fracture
- 1 in 10 people in the UK have a hip fracture
- 1 in 10 people in the UK have a hip fracture

**COPD: Key Facts**

- COPD affects more people than you think
- Each year, COPD costs the NHS £800 million
- COPD is the 5th biggest killer in the UK
- COPD causes 5,500 deaths in the North West each year!

**Sepsis: Key Facts**

- Early recognition and treatment is key
- 70% of sepsis cases are preventable
- 30% of sepsis cases are preventable
- 4 out of 10 people with severe sepsis die

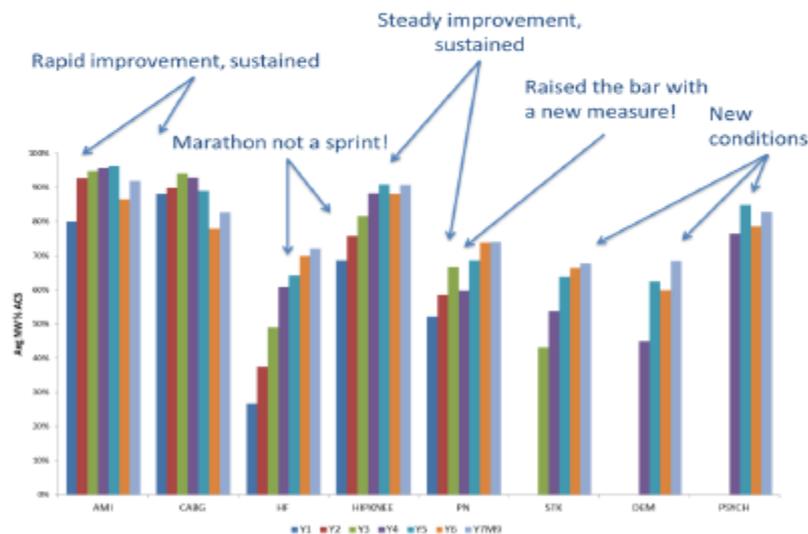
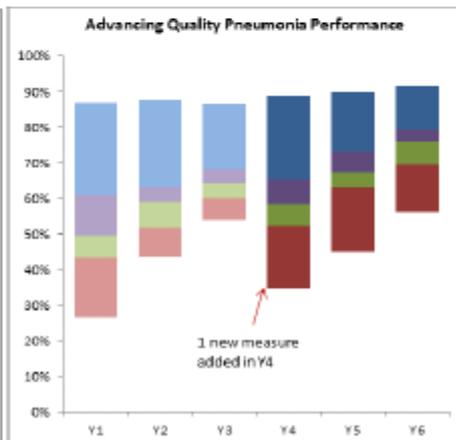
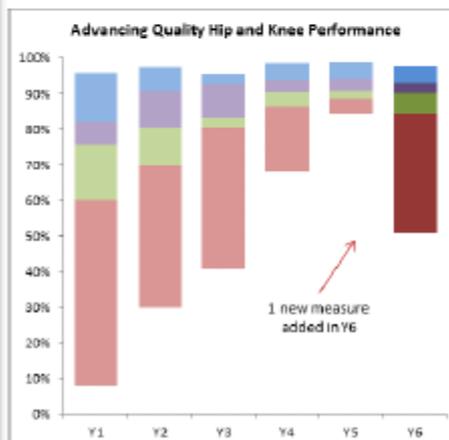
## Results

- Over 100,000 patients per annum (1 in 10) on an AQ pathway.
- All hospitals and all conditions improved.
- Large reductions in variation between services and hospitals.
- More patients now receive 'appropriate care'. The North West Appropriate Care Score for the original 5 AQ conditions in year 1 of AQ was 61% ; in year 6 it was 81%.
- Reduced mortality - 890 fewer deaths in first 18 months.
- Reduced length of stay - 22,802 bed days in first 18 months.
- 8 fold return on investment (QALYs).
- Rate of improvement reduces in later years.

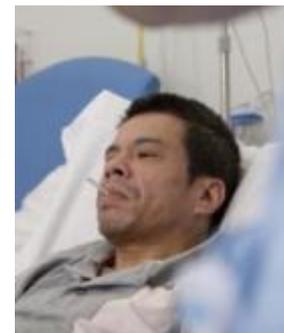
## Results from the 1st 18 months of the AQ programme for all North West Providers

	AMI	Heart Failure	Pneumonia	TOTAL
NW Admissions	11,897	9,304	18,510	39,711
Deaths Averted <sup>1</sup>	110	90	690	890
QALYs <sup>2</sup>	778	26	4,701	5,505
QALY Value <sup>3</sup>	£ 15,560,000	£ 520,000	£ 94,020,000	£ 110,100,000
Bed Days Saved <sup>2</sup>	4,787	2,493	16,540	22,802
Bed Day Value <sup>2</sup>	£ 1,100,000	£ 500,000	£ 3,000,000	£ 4,400,000

## Year on year Appropriate Care Scores by condition



# Waiting Kills!



Vincent Connolly,  
Clinical Director ECIST



## Crowded emergency departments produce worse patient outcomes

- 43% increase in mortality at 10 days after admission through a crowded emergency department (*Richardson*)
- Stays in emergency departments of 4-8 hrs add 1.3 days to admission length of stay; stays >12 hours add 2.35 days (*Liew et al*)
- 70% of antibiotics delayed by over 4 hours when emergency department overcrowded (*Pines*)
- Patients discharged following treatment in a crowded emergency department have a higher risk of death in next 7 days (*Guttmann et al*)

- Richardson DB. *Increase in patient mortality at 10 days associated with emergency department overcrowding*. Med J Aust 2006; 184:213-6
- Liew D, Liew D, Kennedy M. *Emergency Department Length of Stay Independently Predicts Inpatient Length of Stay*. MJA 2003; 179; 524-52
- Pines JM et al. *The impact of emergency department crowding on time for patients with community acquired pneumonia*. Annals of Emergency Medicine, 2005, 50(5): 510-516
- Guttmann A, Schull MJ, Vermeulen MJ, Stukel TA. *Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada*. BMJ 2011; 342:d2983

# AQUA

Advancing Quality Alliance

**NHS**



**Shared Decision Making**

**Mental Health Crisis  
Care Concordat**

*Sign up to*  
.....  
**SAFETY**  
**LISTEN LEARN ACT**



**No Force First**



**Improving Access and  
Experience for people with  
First Episode Psychosis**



# Liverpool Heart and Chest NHS Foundation Trust

Daily Trust wide safety briefing:

- Each department holds an early morning safety ‘huddle’
- Representatives from all areas attend a 9.30 meeting chaired by the CEO
- 20 minute ‘stand up’ meeting covering:
  - Actions from yesterday’s meeting
  - Any new safety incidents in the last 24 hours
  - What are the biggest safety risks for each department today
  - Any other safety concerns
- Immediate actions are agreed as well as wider themes

## Value of the daily Trust wide Safety Briefing

- Makes safety concerns visible in 'real time' and mandates rapid action
- Strongly communicates CEO/senior leader commitment to safety
- Alerts CEO and senior leaders to reality of day to day operations
- Builds a teamwork culture
- Fosters lateral communication and problem solving across departments within the organisation

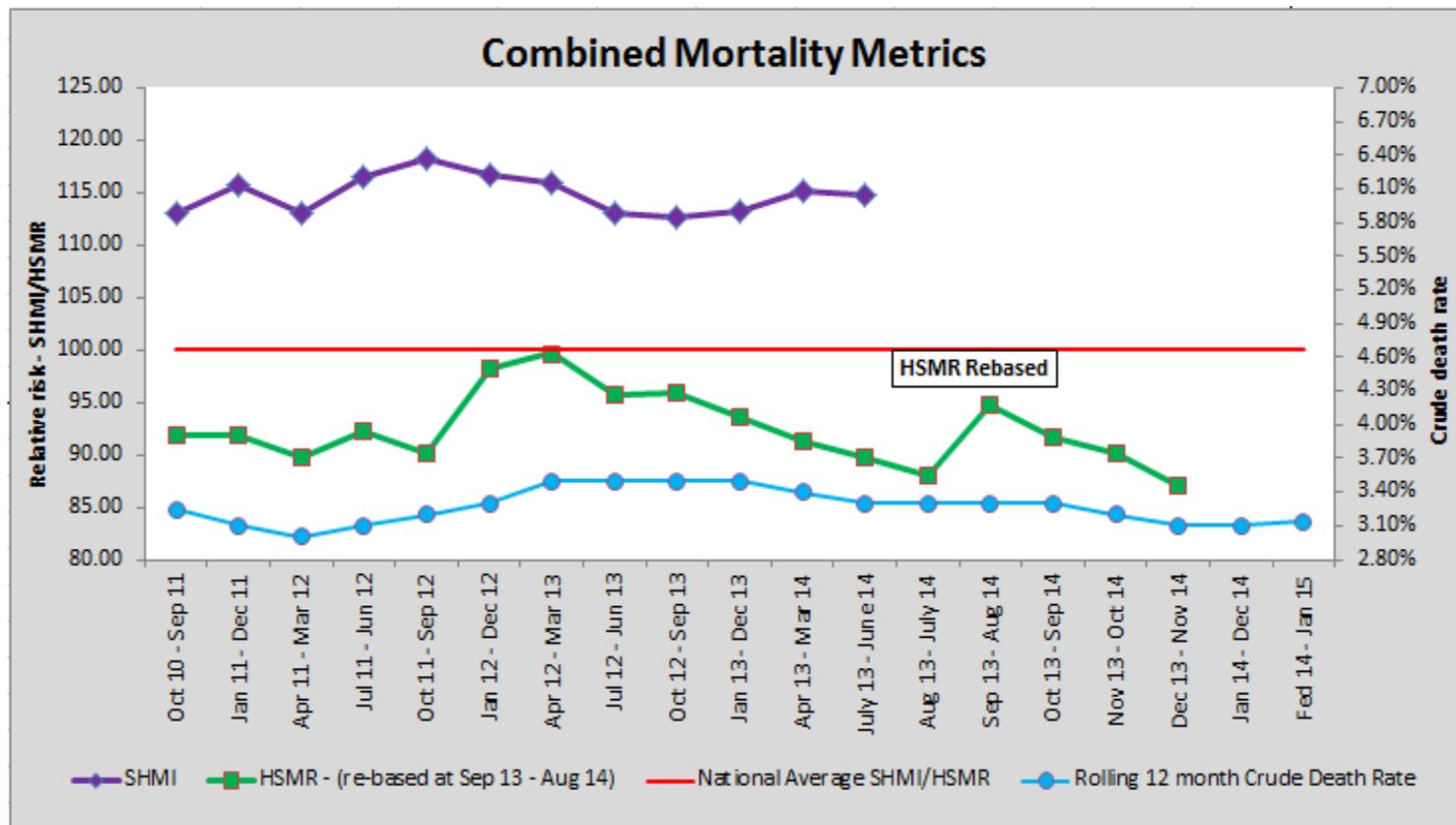
“ This has done more than anything else I’ve known to help us develop a safety culture. It’s fundamentally changing the way I relate to staff in the Hospital and them to me.”

Jane Tomkinson, CEO, LHCFT.

## Aintree UH NHS FT

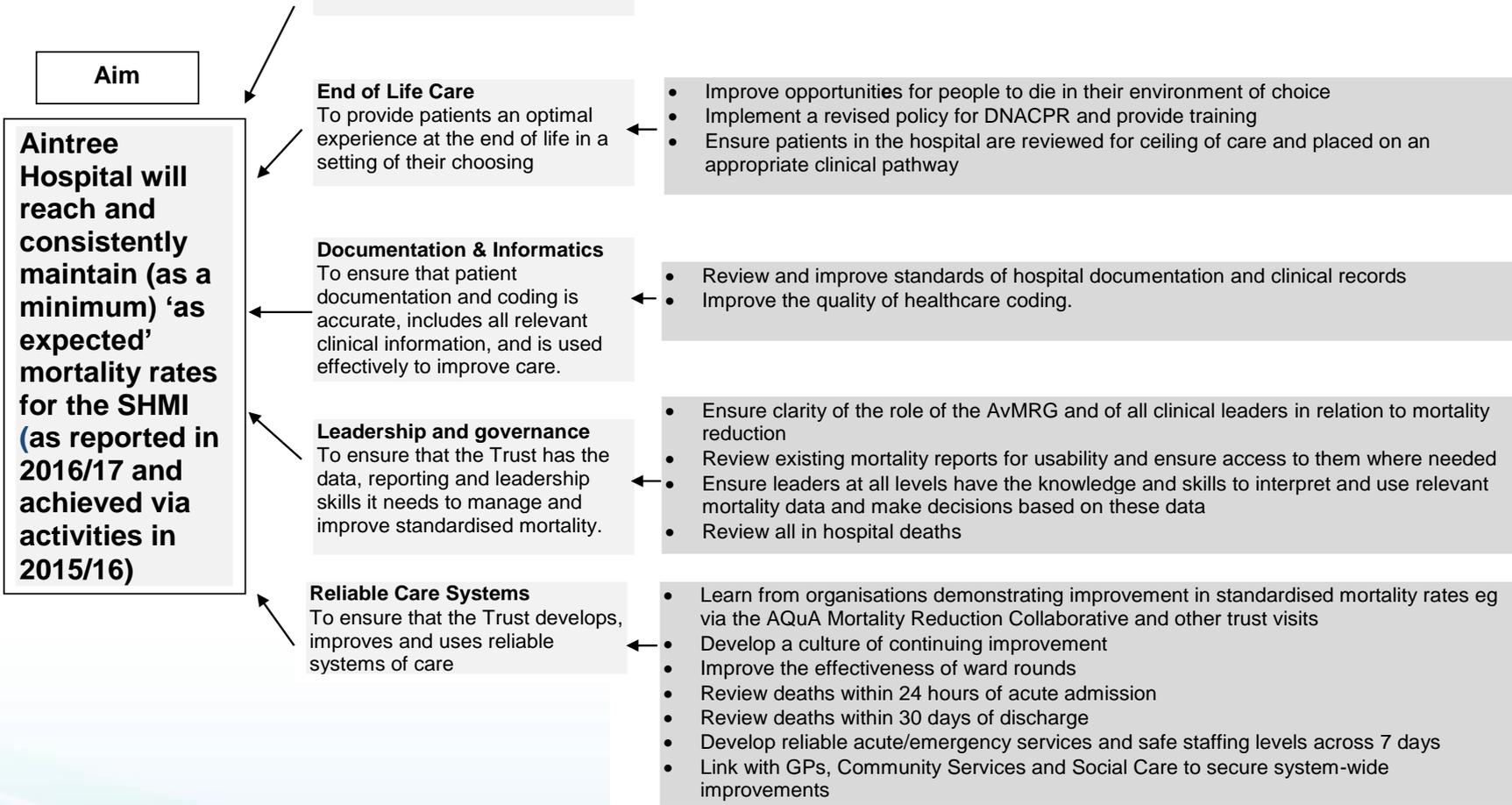
- Low HSMR, high SHMI, average crude rate!
- CQC inspection gave “Good” rating (2014)
- Focus is on driving wider improvements in safety and quality
- Integral to Trust’s Quality strategy
- Strong emphasis on ‘human factors’

# HSMR/SHMI/Crude Death Rate Comparison



**Primary Drivers  
(Objectives)**

**Secondary Drivers  
(Actions)**



## **Mortality reduction work streams**

- Management of sepsis
- Management of pneumonia
- Acute kidney injury
- Management of the deteriorating patient
- End of life care (Amber project)

## So... in conclusion

- The aim must be to improve quality of care and secure a genuine reduction in avoidable deaths
- Mortality rates are a helpful “smoke alarm”... but they don’t tell the whole story
- Mortality rates are difficult to interpret – you need to eliminate any “noise in the data”
- Triangulate standardised rates with crude rates and non mortality data – complaints; quality indicators; staff survey; patient feedback; hands on visits and observations
- Put patients and families centre stage – involve them in the process
- Effective leadership and deep staff engagement at every level are critical to success
- This is a whole system effort and all partners need to take responsibility for it, not just hospitals

Gordon Wood, Medical Director

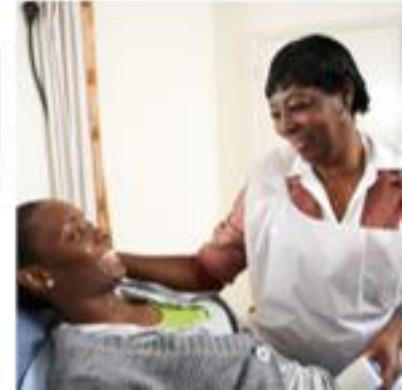
James Avery, Head of Patient Safety & Mortality

# **GEORGE ELIOT HOSPITAL NHS TRUST**

# Acting on mortality data and clinical review findings

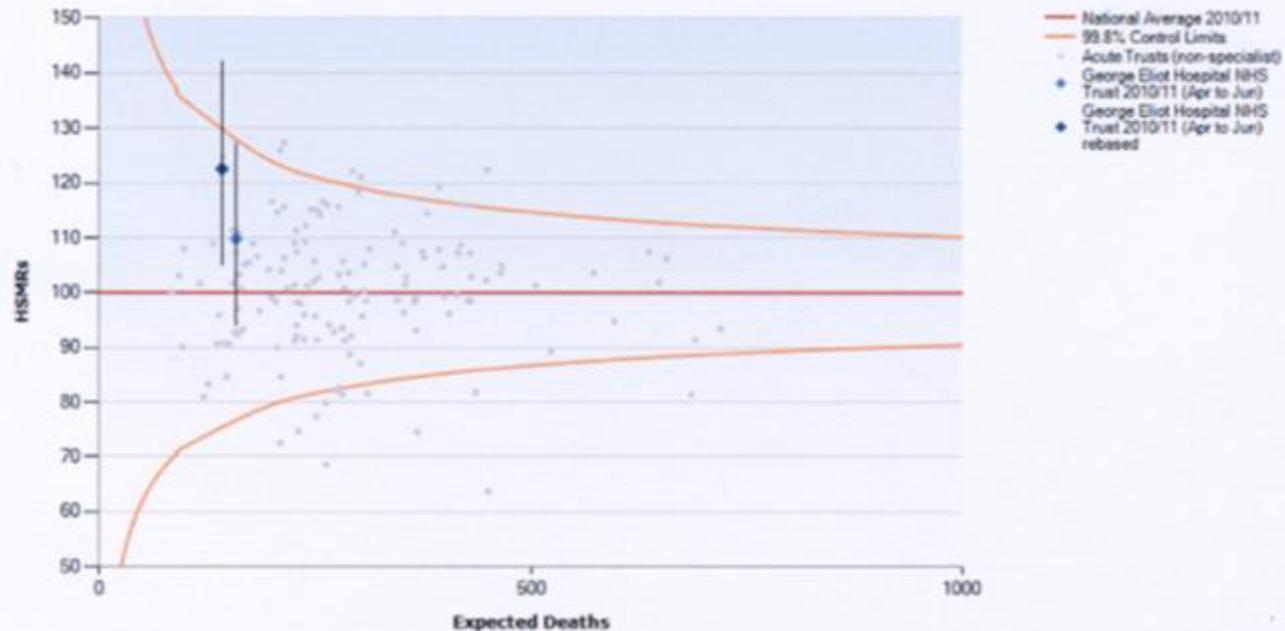
**Dr Gordon Wood**  
Medical Director

**James Avery**  
Head of Patient Safety & Mortality  
Deputy Director of Nursing ( Acting )



# The road to special measures

Acute Trust HSMRs 2010/11 (Apr to Jun)



# Sir Bruce Keogh- July 2013



# Consequences I

## The Observer

### Exposed: hospitals that shame the NHS

- 19 hospitals have high death rates
- NHS 'failing patients' on crucial care

by Denis Campbell and Anushka Aathana

Nineteen hospital trusts are today exposed as having alarmingly high death rates in a major report that also reveals

routine operations. It names Hull and East Yorkshire Hospitals NHS Trust as the place where patients have the highest risk of dying in these circumstances - 66% above the average. Last year that equated to 13 deaths more than expected there, although it is not possible to see

if deaths involving the *Clostridium difficile* have killed in two years in Wales, latest figures

### ame, claims and accusations hospital bug deaths double

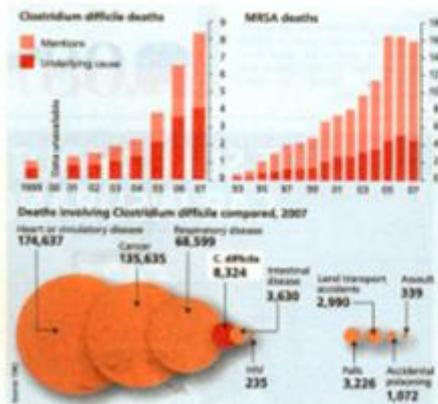
of deaths involving the *Clostridium difficile* have killed in two years in Wales, latest figures

ment has said that it infections linked to the virus by a third by data from the Office for Statistics (ONS) shows a rise in the number of since 2005.

Minister ordered a high- level" of all NHS hospitals earlier this year in order spread of infections

and C. difficile. not falls in the rate of 14 death certificates last year with 6,480 in 2006 - 28 per cent.

with 3,752 mentions in 2005, and "significant increase" since said.



- Hospitals with more than 3 per cent of deaths involving C. difficile
- Blackpool Infirmary, County Hospital, Merseyside
  - General Hospital, Nottingham
  - George Eliot Hospital, Northampton
  - Luton General Hospital
  - Queen's Hospital, Burton-upon-Avon
  - Royal United Hospital, Bath
  - Sunderland Hospital, Essex
  - Stoke Newington Hospital, London
  - West Middlesex Hospital, Brentford

- Hospitals with less than 0.4 per cent of deaths involving C. difficile
- Assesment Unit at General Hospital, Walsley
  - Derford Hospital, Plymouth
  - Elizabeth Princess of Wales Hospital, Bromley
  - James Cook University Hospital, Middlesbrough
  - North Manchester General
  - Royal Infirmary, Doncaster
  - Stokeley Hospital
  - St Christopher's Hospital, Solihull
  - Stagby Hill Clinic, Rotherham
  - Valley General, Benger
- National average: 0.88 per cent

named as a factor in a death would be 72 per cent. The infection was named as the underlying cause of death on about half of the cases last year, the

figures fell slightly to 1,983 in 2007 - the first time total cases of the superbug have fallen since the ONS began keeping records in 1993.

insert a rise in the actual number of deaths, but primarily an "increase in awareness and reporting". He added that the Department of

The... that... 'our... wake

David...

Bacteria will long as prevention infection. It since outbreak caused the d at Maidstone NHS Trust, Sara, Min Health. Pen ding for infe being attend gene and peo to hand the outbreak which were profile since Commission

Now the control at D an array of keep super



# Consequences 2



# Outcomes of Keogh Review May 2013



# Tackling mortality and safety issues



# Obvious actions

## Patient Safety Action & Achievements

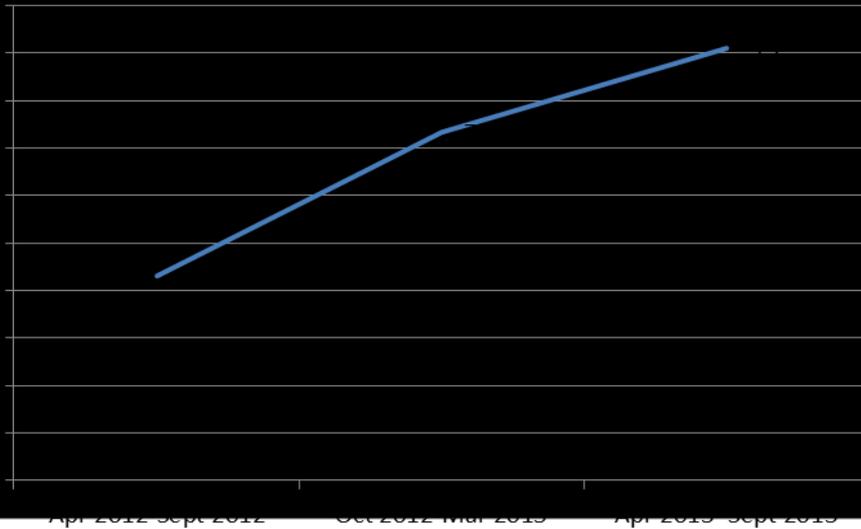
ng

strengthened



# Obvious actions

## Incident Reporting



[Redacted text block]



# North West London Hospitals NHS Trust

## Measuring compliance, improving reliability through care bundles

### So what did we do?

- Looked at top 25 causes of mortality across the Trust
- Targeted eight areas for care bundles
  - > Stroke
  - > Heart Failure
  - > C.Diff
  - > VAP
  - > COPD
  - > MRSA
  - > CVC
  - > SSI



# North West London Hospitals NHS Trust

## Measuring compliance, improving reliability through care bundles

- What Changed
- The standardised mortality ratio (SMR) of the targeted CCS diagnoses and the HSMR both showed significant reductions at the 95% confidence interval level. There was a non-significant reduction in the SMR of the non-targeted diagnoses. The HSMR of the trust reduced from 89.6 in 2006-07 to 71.1 in 2007-08, the lowest of the acute trusts in England. There were 255 fewer deaths in the trust in 2007-08 than there would have been if the 2006-07 HSMR had been applicable (174 of these in the targeted CCS diagnoses).



# Approach

Acute Kidney Injury Care Bundle				
<b>PART A</b>				Date and Time of Admission:
AFFIX STICKER				Ward:
NAME				Consultant:
DOB				
HOSPITAL NUMBER				
NHS NUMBER				
<b>PART B</b> Inclusion Criteria				
Bundle to be used in any of the following:				
A+ Rising Creatinine 1.5x increase for baseline OR >177 if no previous results				
OR B+ Oliguria Urine Output <0.5ml/kg/hr for >4hr confirm poor output with bladder scan or ensure catheter patent				
<b>PART C</b> Acute Kidney Injury Bundle 7 Actions Complete in 1 hour				
		Confirms complete / Reason for variance	H1H188	Signed
		Yes	Reason	
Give Oxygen to correct target saturations (94-98% unless COPD/BH/SDA)				
Give IV fluid challenges 200ml stat. Maximum of 2 times. Review and repeat until CRT <3 and TMP >70, or signs of overload.				
Take Bloods and Samples VBG for lactate and Ph if abnormal acute AKI, Lactate, Urea, HbC, LFT, CK, CrP, Coag HbA1c/CGU if relevant				
Prevent further injury Stop NSAIDs, ACE i, Diuretics, Metformin, statins; Review drug doses (e.g. adjust creatine and potassium doses)				
Start and ensure full Obs and Urine Output recorded hourly Likely to need catheterising				
Screen for likely causes Sepsis, Heart failure, Liver failure				
Refer "Suspected AKI" to Registrar and Critical Care Outreach				
<b>Monitor your Patient closely!</b>				
Actions for Failure to Respond OR Deterioration		Time of call	Referred Cons. / Reg. Name	
1. Escalate to Registrar / Consultant within 0-1 hours; if after completing AKI 7 • MAAP < 70mmHg • Urine output remains < 0.5ml/kg/hr for 2 hours • Signs of Fluid Overload. • Serum Potassium > 6				
2. Escalate if appropriate, to ITU Registrar/ Consultant within 0-3 hours				
3. Renal USS to be performed within 24 hrs (in patients suspected to have urinary tract obstruction and in those where cause of AKI not clear)				
<b>Instructions</b>				
1. Check inclusion criteria part B				
2. If inclusion criteria met Complete Patient details in Part A				
3. Follow actions in Part C & record completion. File bundle / place sticker in notes as treatment record				
<small>Acute Kidney Injury Care Bundle Version 1 June 2014 Review June 2015</small>				



# Investigation process example

Case Identification (xxx Cases xxx Deaths)

Pathway and case review

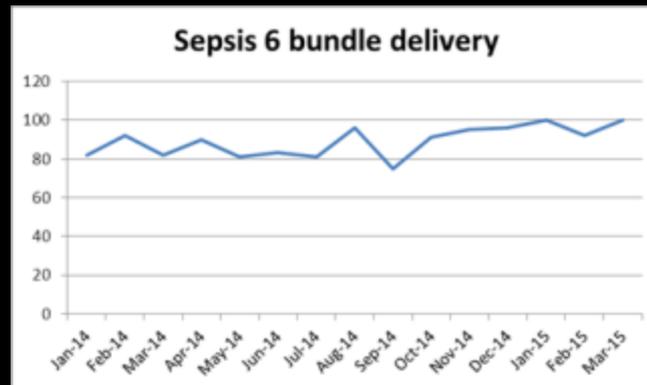
Local Patient Identifier	Comorbidity Score	Palliative Care	Mortality Probability	Admission Method	Weekend Admission	Primary Operation Code	Treatment Specialty Code	Consultant Code	Main Specialty	Dominant Diagnostic Group Code	Dominant Diagnostic Group
XXXXXXX	5	0	24%	Non-elect	Non-week	L912	300	C1234567	300	R650	Systemic Inflammatory
XXXXXXX	4	0	19%	Non-elect	Non-week	E851	300	C1234568	300	R572	Septic shock
XXXXXXX	3	0	25%	Non-elect	Non-week	X404	300	C1234569	300	R572	Septic shock
XXXXXXX	24	1	71%	Non-elect	Weekend	U212	300	C1234570	300	A419	Sepsis, unspecified

Presentation of results

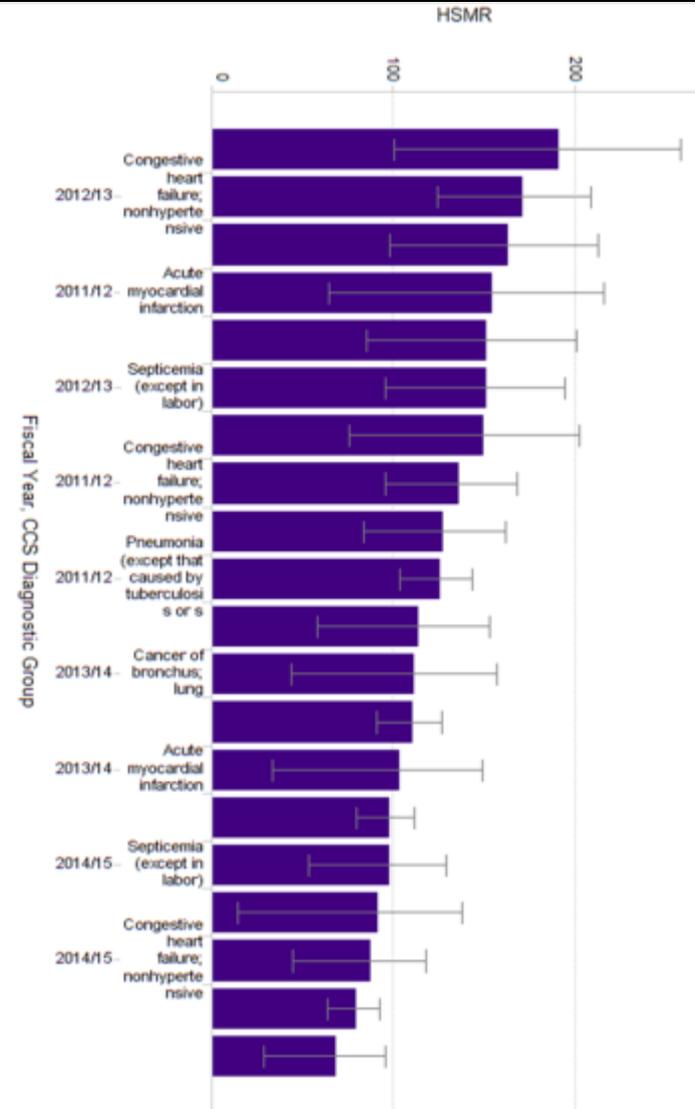
Improvement of results



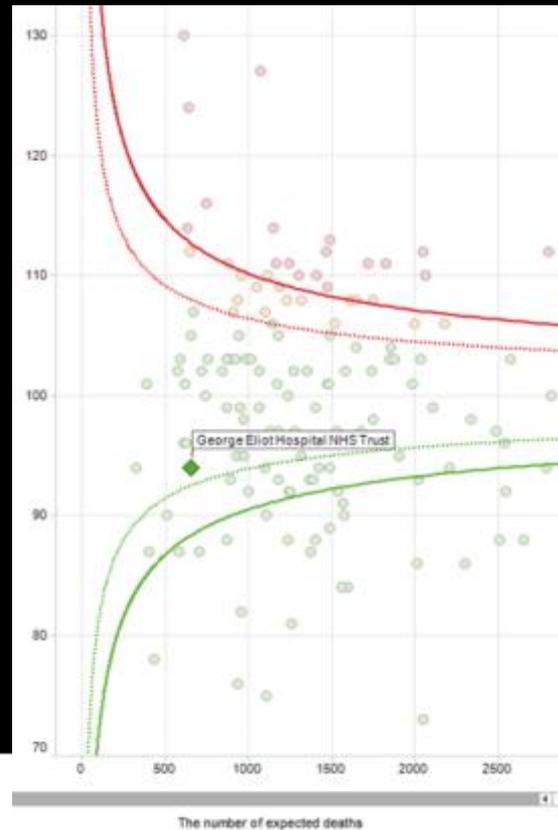
# GEH actions



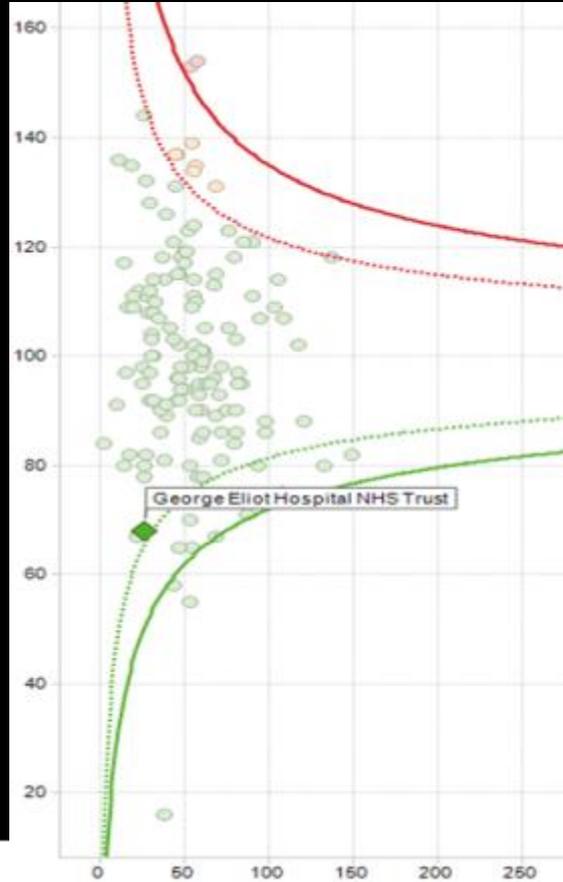
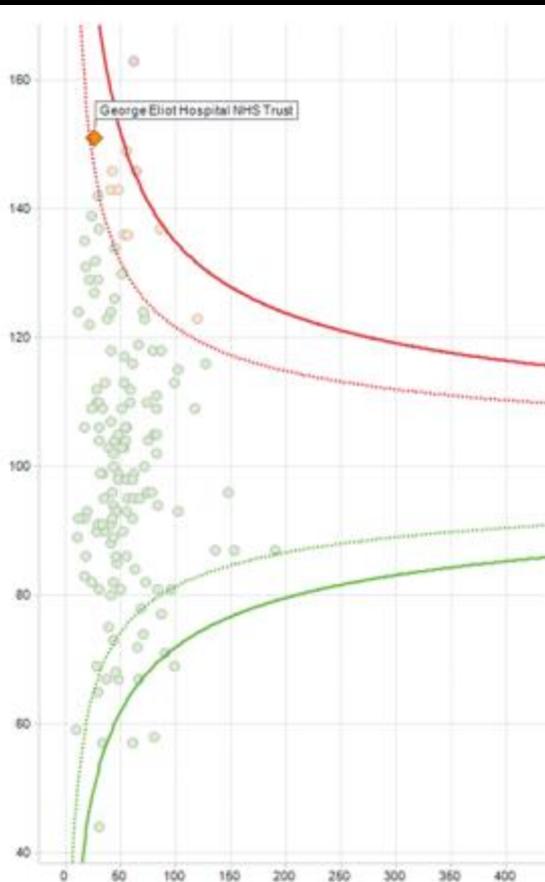
# Results



Fiscal Year	Admission Day	HSMR	HSMR Crude Mortality Rate	HSMR Combined	SHMI	SHMI In-hospital Crude Rate	SHMI Combined
2012/13	Weekday	116.37	6.30%	119.29	108.07	3.1	1.09
2012/13	Weekend	128.4	9.96%		111.93	3.9	
2013/14	Weekday	101.65	5.38%	100.09	99.24	2.8	0.98
2013/14	Weekend	95.35	7.22%		97.32	3.1	



# Results



### Sepsis / Neurosepsis Sepsis Screening and Treatment Pathway

Adult (16-65 years)  Child (6-16 years)  Neonate (0-5 years)

Highly vulnerable patient (see annotation)

Ward / Area: \_\_\_\_\_

Referred by: \_\_\_\_\_

George Eliot Hospital

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Ward / Area: \_\_\_\_\_

Referred by: \_\_\_\_\_

Are any 2 of the following **SOFA** criteria present?

**Respiratory**  Temperature  $\geq 38.3^{\circ}\text{C}$  or  $\leq 36.0^{\circ}\text{C}$   Respiratory rate  $\geq 20$  with Acutely elevated mental status

**Neuro**  Mean Arterial Pressure (MAP)  $\leq 65$  mmHg  **Urine**  **Coagulation**

If patient has had chemotherapy in last 8 weeks or known Neutropenia follow "Y"

Is there suspected or documented infection?

**Source**  **Abx**  **Respiratory**  **UTI**  **Septic**  **Septic**  **Septic**  **Septic**

Assess Severity of Sepsis

Is at least one of these **qSOFA** signs present?

Respiratory rate  $\geq 10$   **Septic**  **Septic**  **Septic**

Liberty Red Flag Sepsis

Assess Sepsis Severity

Respiratory rate  $\geq 10$   **Septic**  **Septic**  **Septic**

Referred to: \_\_\_\_\_

Medical / CCOT Review / Starting Time: \_\_\_\_\_

For Sepsis 6?

Start Sepsis 6 immediately

Start Sepsis 6

Complete pathway checked

### Sepsis Six Treatments and Investigations - complete in 1 hour and Review

**Mandatory, check raised and satisfied**

Sepsis Six	Time	Name	Liberty red flag	Investigation	Time	Escalation
Give High Flow O <sub>2</sub> to achieve target SpO <sub>2</sub> (see annex 1 on respiratory)				SpO <sub>2</sub> $\geq 94\%$		Escalate if 'Yes' to any this
Take Blood Culture (see annex 2 on blood culture)				See the blood culture report		Escalate Sepsis if
Give IV antibiotics (see annex 3 on antibiotics)				See the antibiotic report		Escalate Sepsis if
Give a fluid challenge (see annex 4 on fluid challenge)				See the fluid challenge report		Escalate Sepsis if
Measure lactate (see annex 5 on lactate)				See the lactate report		Escalate Sepsis if
Monitor Other Critical Measurements and NEWS				See the NEWS report		Escalate Sepsis if
Response / Consultant Present						Escalate Sepsis if
Investigate cause referred appropriate						Escalate Sepsis if
Time referred to						Escalate Sepsis if
Referred to						Escalate Sepsis if

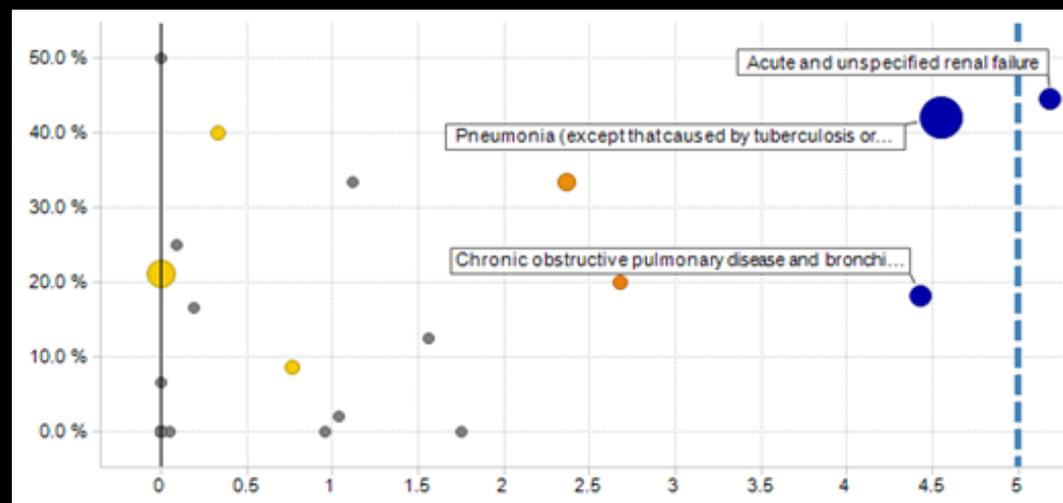


# Mortality Review

- 1 Not avoidable
- 2 Slight evidence for avoidability
- 3 Possibly avoidable but not very likely, less than 50-50 but close call
- 4 Probably avoidable, more than 50-50
- 5 Strong evidence for avoidability
- 6 Definitely avoidable



# Mortality Review



# Mortality review versus HSMR- complementary information

RESEARCH

OPEN ACCESS

## Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis

Helen Hogan,<sup>1</sup> Rebecca Zifet,<sup>2</sup> Jenny Neuburger,<sup>2</sup> Andrew Hutchings,<sup>2</sup> Ars Dartz,<sup>2</sup> Nick Black<sup>2</sup>

<sup>1</sup>Department of Health Services Research & Policy, London School of Hygiene & Tropical Medicine, London WC1E 6HT, UK  
<sup>2</sup>Department of Surgery & Cancer, St Mary's Hospital, Imperial College, London, UK

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© See also: [doi:10.1136/bmj-2018-026439](#)  
doi:10.1136/bmj-2018-026439  
Accepted: 30 May 2018

**ABSTRACT**  
**OBJECTIVES**  
To determine the proportion of avoidable deaths (due to acts of omission and commission) in acute hospital trusts in England and to determine the association with the trust's hospital-wide standardised mortality rate assessed using the two commonly used methods—the hospital standardised mortality rate (HSMR) and the summary hospital level mortality indicator (SHMI).

**DESIGN**  
Retrospective case record review of deaths.

**SETTING**  
34 English acute hospital trusts (16 in 2009 and 24 in 2012/13) randomly selected from across the spectrum of HSMR.

**MAIN OUTCOME MEASURES**  
Avoidable death, defined as those with at least a 50% probability of avoidability in view of trained medical reviewers. Association of avoidable death proportion with the HSMR and the SHMI assessed using regression coefficients, to estimate the increase in avoidable death proportion for a one standard deviation increase in standardised mortality ratio.

**PARTICIPANTS**  
100 randomly selected hospital deaths from each trust.

**RESULTS**  
The proportion of avoidable deaths was 3.4% (95% confidence interval: 2.0% to 4.7%). It was lower in 2012/13 (3.0%, 2.4% to 3.7%) than in 2009 (5.2%, 3.8% to 6.6%). This difference is subject to several factors, including reviewers' greater awareness in 2012/13 of orders not to resuscitate, patients being perceived as sicker on admission, minor differences in review form questions, and cultural changes that might have discouraged reviewers from criticising other clinicians. There was a small but statistically non-significant association between HSMR and the proportion of avoidable deaths (regression coefficient 0.3, 95% confidence interval -0.2 to 0.7). The regression coefficient was similar for both time periods (0.1 and 0.3). This implies that a difference in HSMR of between 105 and 115 would be associated with an increase of only 0.3% (95% confidence interval -0.2% to 0.7%) in the proportion of avoidable deaths. A similar weak non-significant association was observed for SHMI (regression coefficient 0.3, 95% confidence interval -0.1 to 1.0).

**CONCLUSIONS**  
The small proportion of deaths judged to be avoidable means that any trends based on mortality is unlikely to reflect the quality of a hospital. The lack of association between the proportion of avoidable deaths and hospital-wide SMRs partly reflects methodological shortcomings in both metrics. Instead, reviews of individual deaths should focus on identifying ways of improving the quality of care, whereas the use of standardised mortality ratios should be restricted to assessing the quality of care for conditions with high case fatality for which good quality clinical data exist.

**Introduction**  
For over 20 years the overall standardised mortality ratio (SMR) for all deaths in a hospital has been advocated as an indicator of the quality (encompassing both safety and effectiveness) of a hospital.<sup>1</sup> Although an association between the SMR for a specific disease (such as acute myocardial infarction, pneumonia, and severe sepsis) and measures of quality of care (such as adherence to clinical guidelines) has been shown,<sup>2-4</sup> similar studies on hospital-wide SMRs have not been reported. Despite concerns about the value of hospital-wide SMRs being raised by experts in the United Kingdom,<sup>5</sup> United States,<sup>6</sup> and Australia,<sup>7</sup> many countries have adapted them and continue to use them.

The Krough review<sup>8</sup> used hospital-wide SMRs to select acute hospital trusts (National Health Service organisations that comprise either a single hospital or a group of local hospitals) in England for detailed consideration of their quality.<sup>9</sup> This review was established in February 2013 in the wake of the second Francis report into Mid Staffordshire NHS Foundation Trust.<sup>10</sup> It aimed "to review the quality of care and treatment provided by those NHS trusts and NHS Foundation

**WHAT IS ALREADY KNOWN ON THIS TOPIC**  
Hospital-wide standardised mortality ratios (SMRs) are commonly used as an indicator of a hospital's quality but have not been validated.  
The proportion of hospital deaths judged to be avoidable based on retrospective case record review has been reported to be about 4-5%.  
The association between hospital-wide SMRs and the proportion of avoidable deaths is uncertain; one study found no association but was too small to provide definitive evidence.

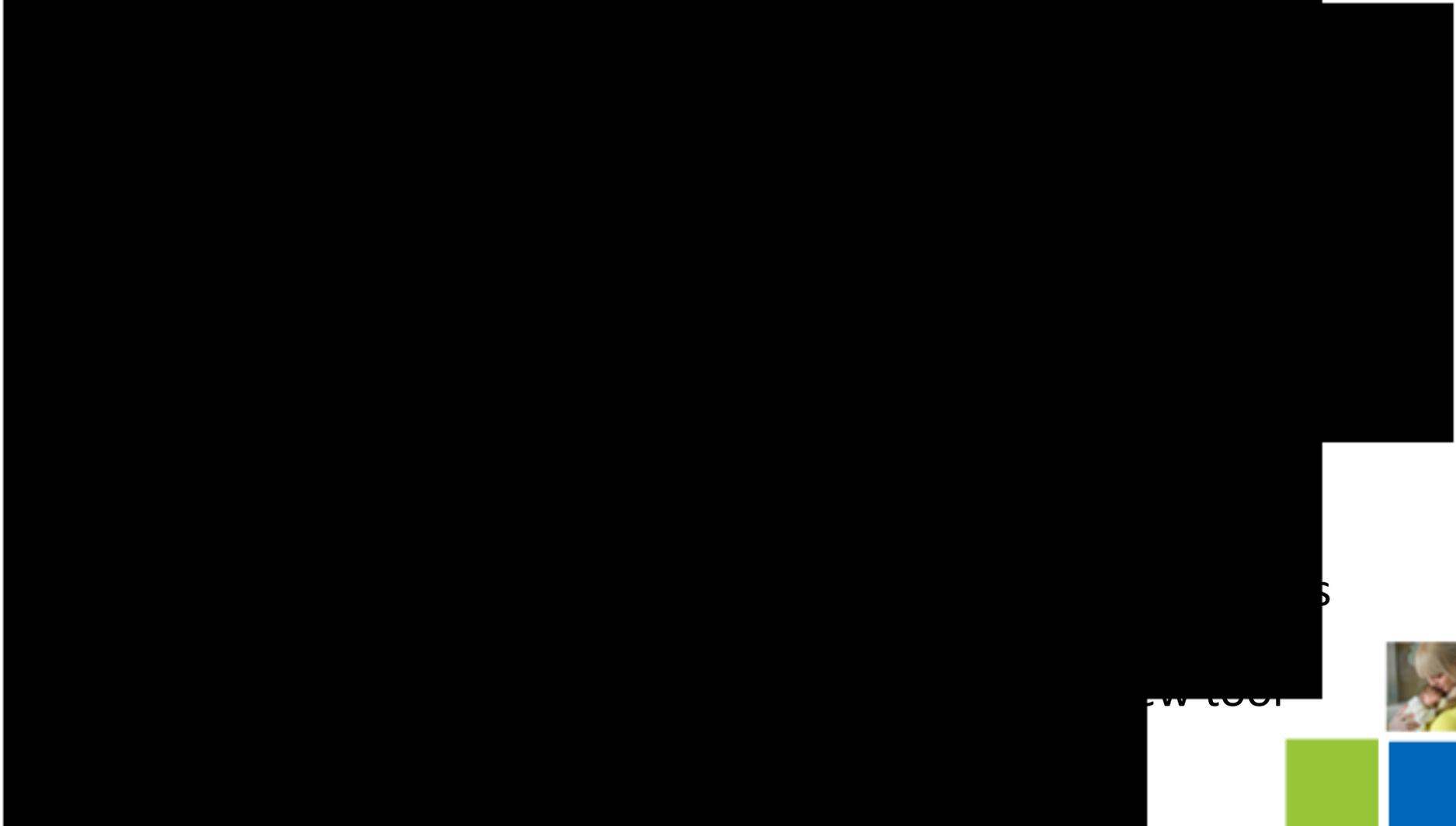
**WHAT THIS STUDY ADDS**  
The lack of a statistically significant association between hospital-wide SMRs and the proportion of avoidable deaths was confirmed.  
Both hospital-wide SMRs and avoidable death proportions based on the judgement of only one or two reviewers have methodological shortcomings making them unreliable indicators to compare the quality of hospitals.

For more: [doi:10.1136/bmj-2018-026439](#)

1



# Next Steps



SW tool



# CQC Ratings

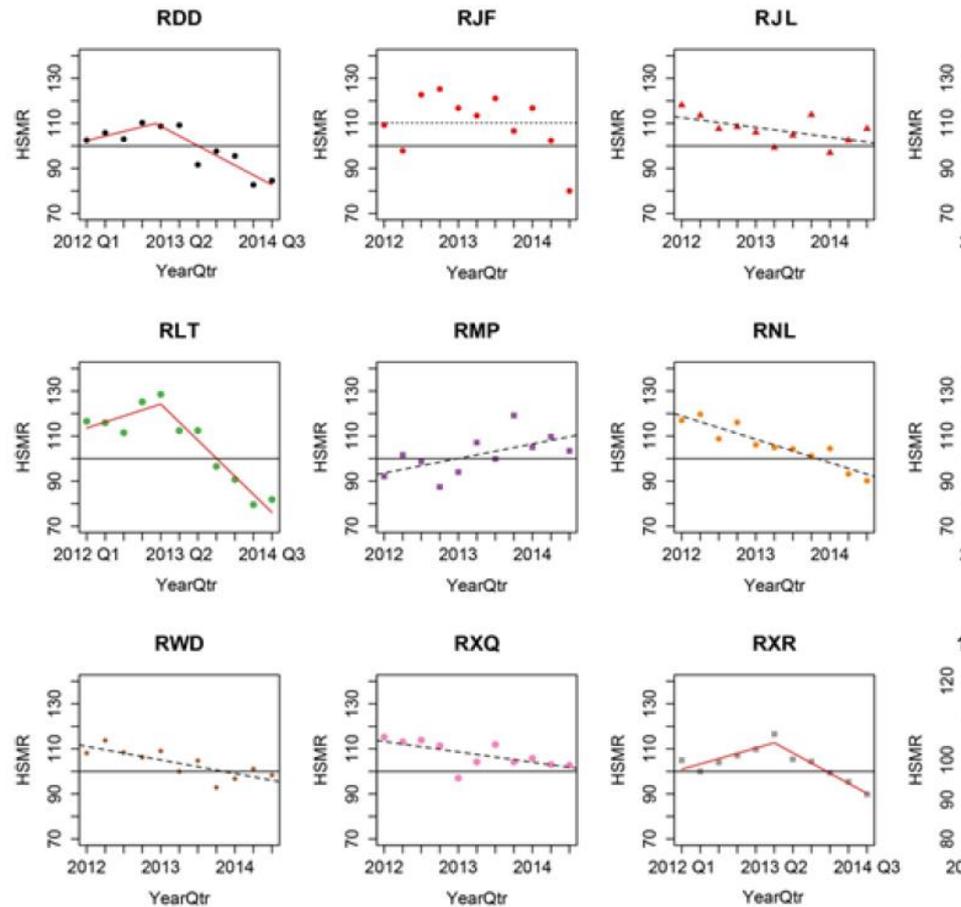
	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Inspected but not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity & family planning	Good	Good	Good	Good	Requires improvement	Good
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Outstanding	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall location	Requires improvement	Good	Good	Good	Good	Good

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Good	Good	Good



# Dr Foster review on Special Measures Trusts

February 2015



# Media Perspectives

SNP-05 52 (NN)

NUNEATON NEWS Monday, July 13, 2015 7

## Eliot death rates are below average

By Lisa Buckley

[lisa.buckley@nuneaton-news.co.uk](mailto:lisa.buckley@nuneaton-news.co.uk)

**GEORGE Eliot Hospital is below the national average in terms of the number of patient deaths on the wards.**

Latest figures for mortality at the Nuneaton NHS Trust reveal that it is continuing to demonstrate 'sustained improvement'.

The positive news was announced at a meeting of the Trust Board, with medical director Gordon Wood explaining the facts behind the figures for the month of May.

In a section of an integrated performance report put together by Mr Wood, it states: "Quality indicators continue to perform well, with an improvement in falls and further success being reported in the full year re-based HSMR (hospital standardised mortality ratio) that shows achievement of a figure below 100, reflecting mortality below national average and demonstrating sustained improvement."

Some of the work being carried out on the wards which are in part behind the success, include special care bundles for patients.

The hospital is also monitoring key conditions including Sepsis, Pneumo-



nia while keeping an eye on antibiotic use.

However while HSMR is reporting low rates, a re-based SHMI (summary hospital-level mortality indicator), which is another nationally recognised indicator of performance, does reveal an increase in January to above expected levels.

A review is to be launched into this involving GPs as a third of the deaths occurred after the deceased patients were discharged from the wards of the

hospital.

In the report Dr Wood explained: "A re-based SHMI has been released and this had increased in January to above expected levels. A review of data shows a range of diagnosis groups outside of expected levels and each is being reviewed in respect to avoidable mortality

"As 30 per cent of these deaths within this time occurred after hospital discharge, GPs will be asked to participate in a review process."



# Thank you for listening

james.avery gordon.wood @geh.nhs.uk



Healthcare Evaluation Data (HED)  
Driving quality and efficiency

LATEST Quarterly SHMI Update- Sept 14

James Avery  
GEORGE ELIJOT HOSPITAL NHS TRUST (RLT)

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## Upcoming Dates

June 2015						
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8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

## My Favourites

Edit

- MaCCBORG
- cardiac cqc group
- Respiratory CQC HESTMORT25
- Med Readmissions
- LOW BIRTH WEIGHT
- short gestation

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Dr Paul Dodds, Medical Director and Deputy Chief Executive  
Mrs Julie Smith, Director of Nursing and Quality

# **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

# Mortality Rates

## Seize the Opportunity

## Change the Headlines

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Dr Paul Dodds  
Medical Director

Mrs Julie Smith  
Director of Nursing and Quality

# Outline of the Session

- Background to the Trust
- Outline where we were and what was the plan
- Describe what we did, focusing on mortality
- Update on where we are
- Highlight what we think worked well – and not so well
- Won't bore you with loads of data – promise!!

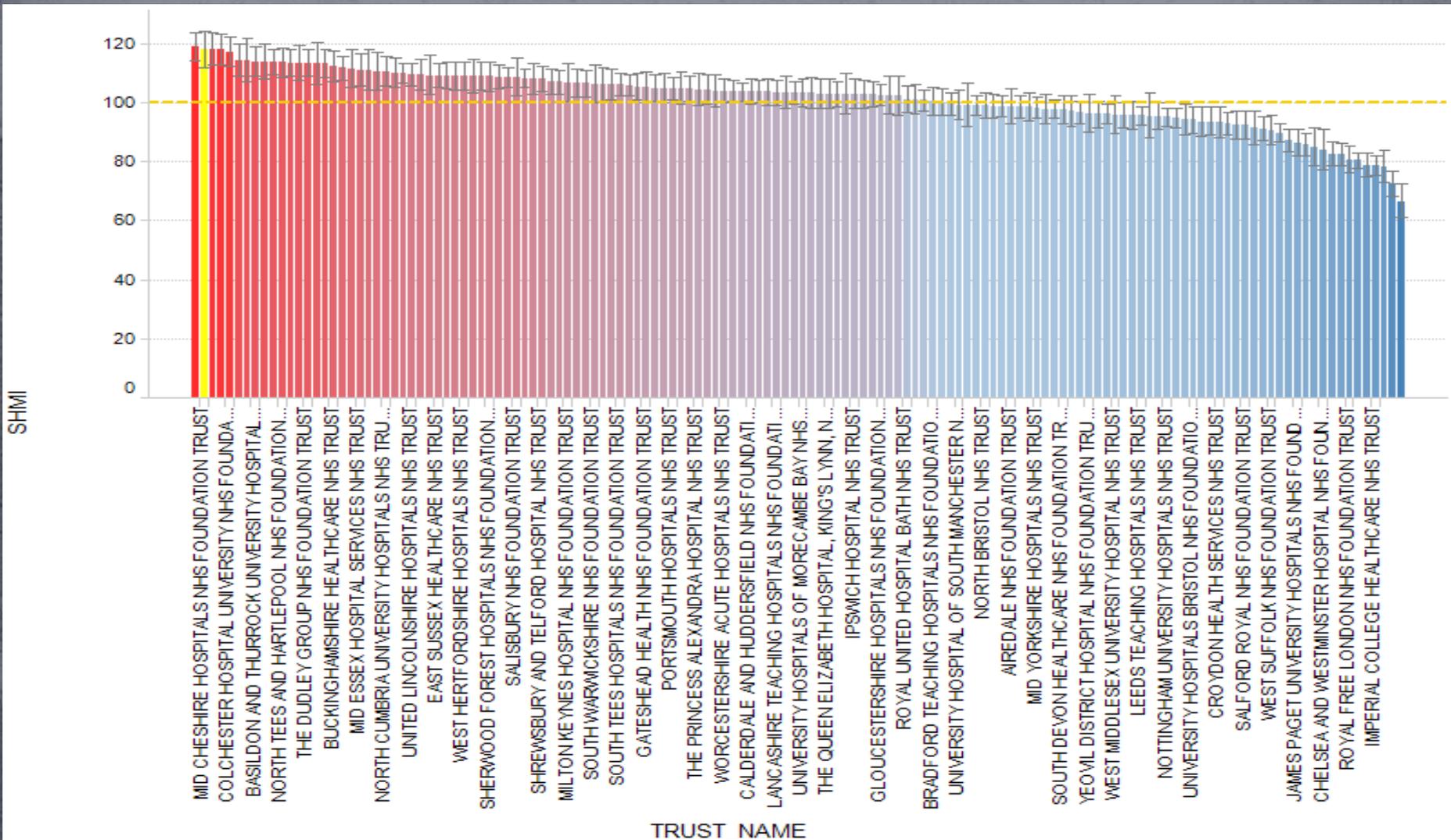
# Assumptions

- Know about SHMI, HSMR, RAMI, crude mortality rates
- Understand the basic differences between the various mortality rate methodologies
- Understand the basics around hospital data sets and clinical coding

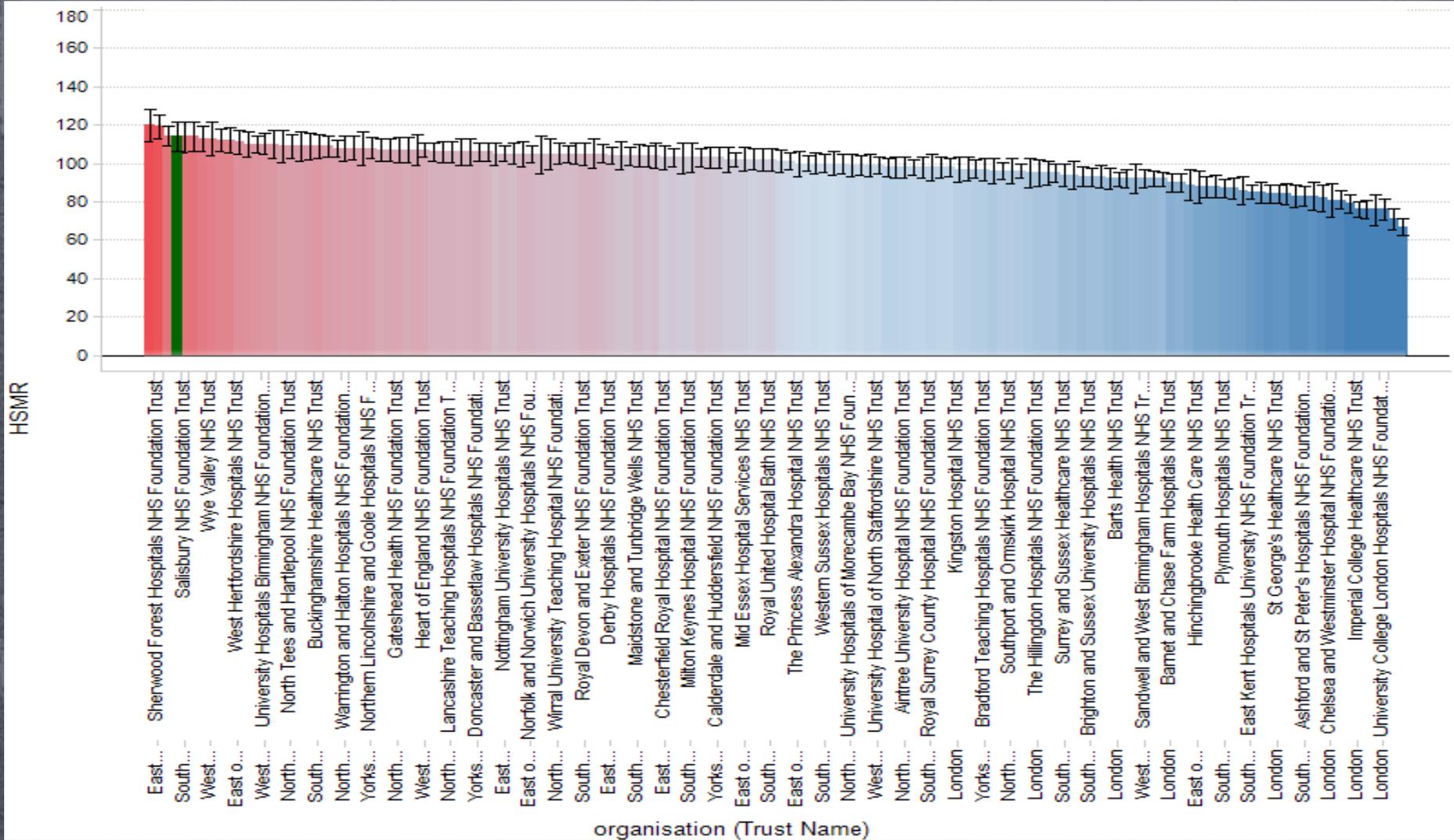
# Mid Cheshire Hospitals NHS Foundation Trust

- District General Hospital
- Catchment population approximately 300,000
- 580 beds
- 3500 staff
- Rated “Good” following CQC Inspection in October 2014

# SHMI (April 12 – March 13) = 1.16



# HSMR (April 12 – March 13) = 114.5



# Mid Cheshire Hospitals NHS Foundation Trust Board of Directors



**Julie Smith**  
Director of Nursing  
and Quality



**Mark Oldham**  
Director of Finance



**Tracy Bullock**  
Chief Executive



**Dr Paul Dodds**  
Medical Director  
and Deputy Chief  
Executive



**Denise Frodsham**  
Chief Operating  
Officer



**Wendy Marston**  
Director of Service  
Transformation and  
Workforce



**John Church**  
Non-Executive  
Director



**Ruth McNeil**  
Non-Executive  
Director



**David Hopewell**  
Senior Independent  
Director



**Dennis Dunn MBE**  
Chairman



**Dame Patricia Bacon**  
Deputy Chairman



**John Barnes**  
Non-Executive  
Director



**Mike Davis**  
Non-Executive  
Director

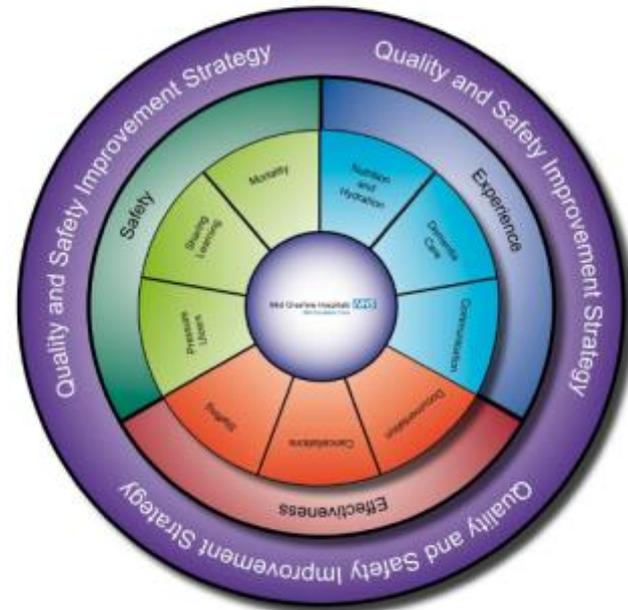
# Board Level Behaviours

- Role model the vision and values
- Champion the message
- Relentlessly promote quality, safety and experience
- Listen to staff and patients
- Celebrate success



# Summary of Strategic Plan

2014/15 to 2018/19



## Quality and Safety Improvement Strategy

2014-2016

# AQUA

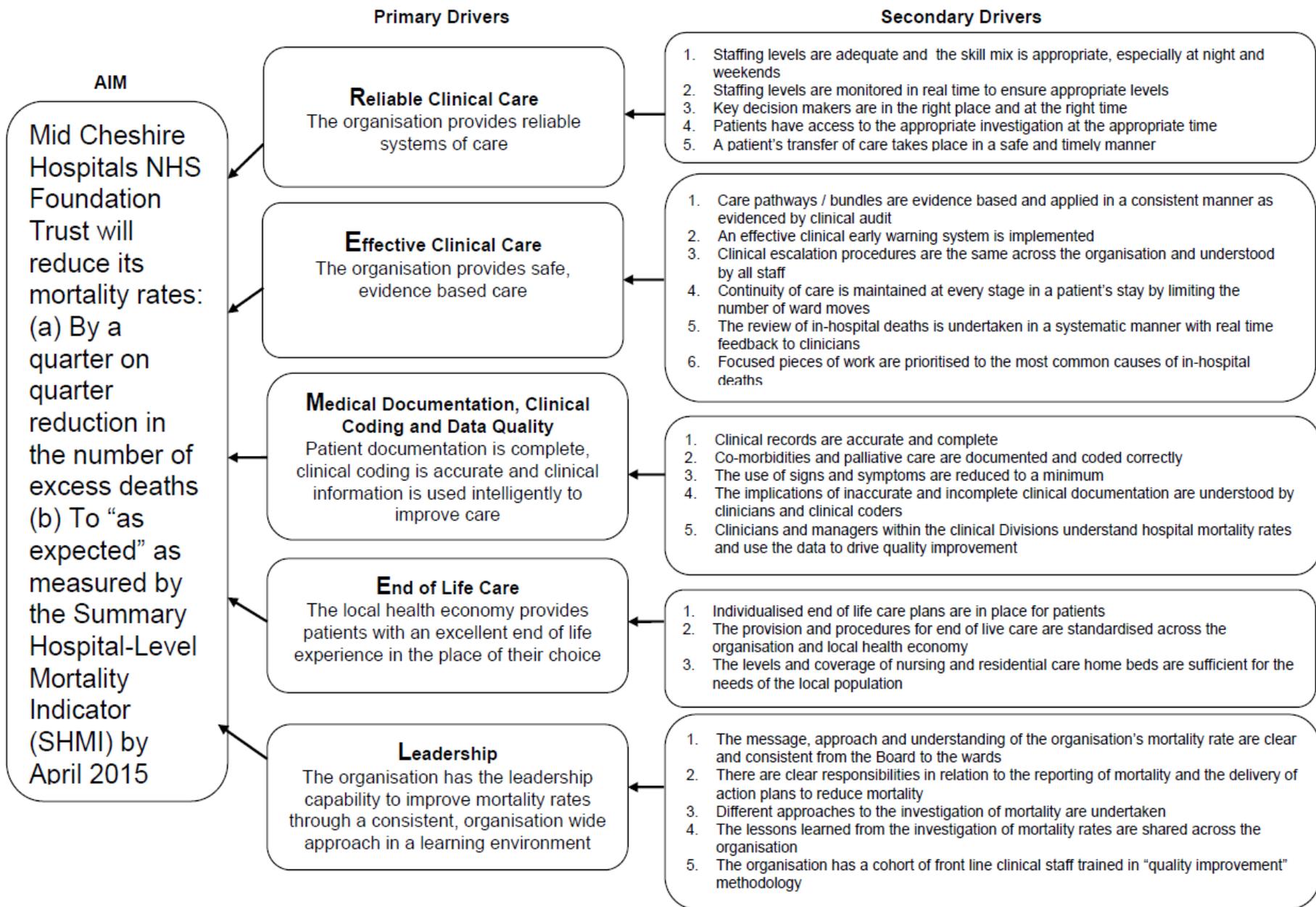
Advancing Quality Alliance



**2-Day Advanced Board Programme on Quality and Safety for  
Provider Trusts**

**Mid Cheshire Hospitals NHS Foundation Trust**  
**Mortality Review**

February 2014



# Primary Drivers

- **R**eliable clinical care
- **E**ffective clinical care
- **M**edical documentation, clinical coding and data quality
- **E**nd of life care
- **L**eadership

# Reliable Clinical Care

- Are staffing levels adequate and is the skill mix appropriate, especially at night and at weekends?
- Are key decision makers in a place where they can make key decisions?
- Do patients have access to the appropriate investigations at the appropriate time?

# Effective Clinical Care

- Do we apply care pathways / bundles in a consistent way?
- Have we prioritised our lines of enquiry to focus on the most common causes of in-hospital death?
- Do we undertake regular reviews of case notes of patients who have died in a systematic manner?
- Do we have an effective clinical early warning system?

# Medical Documentation and Clinical Coding

- Are our clinical records accurate and complete?
- Is the use of signs and symptoms reduced to a minimum?
- Are the implications of inaccurate or incomplete clinical records understood by clinicians?
- Are the co-morbidities documented and coded correctly?

**GET IT RIGHT  
FOR YOUR PATIENTS** ✓

Your clinical assessment and diagnostic opinion should be clear and accurate to ensure good patient care and clinical communication with your colleagues.

Clinical coders use your notes to record diagnoses in the hospital's IT system.

It is vital that these entries are correct.

CODERS CAN CODE	THEY CANNOT CODE
✓ A clearly written diagnosis	✗ Possible ...
✓ Probable ...	✗ Impression ...
✓ Presumed ....	✗ Imp ...
✓ Treat As ...	✗ Likely ...
✓ △ ...	✗ ?

**RECORD DIAGNOSIS & TREATMENT PLANS CLEARLY**

# End of life care

- Are individualised end of life care plans in place for patients?
- Are provision and procedures related to end of life care standardised within your organisation and across the local health economy?

# Leadership

- Is the message, approach and understanding of our mortality rates clear and consistent at all stages from “Board to ward”?
- Are the lessons learned from the investigation of mortality rates shared across the organisation
- Does the organisation have a cohort of front line clinical staff trained in “Quality Improvement” methodology

## MCHFT CLINICAL LEADERS DEVELOPMENT PROGRAMME 2012 - 2014

The Clinical Leaders Development Programme has been established

- To provide a supportive environment in which clinicians can develop and expand their leadership knowledge and skills, reflect on their capabilities and explore new ways of behaving.
- To allow those interested in clinical leadership to network and share best practice with other clinical and managerial colleagues.
- To enable the process of talent management and succession planning for clinical leadership roles at MCHFT.
- Around the 5 domains of the NHS Institute's Medical Leadership Competency Framework.



Who would benefit from attending?

- Anyone interested in clinical leadership who wishes to develop their leadership knowledge and skills for the benefit of patients and MCHFT.

What should you expect from the programme?

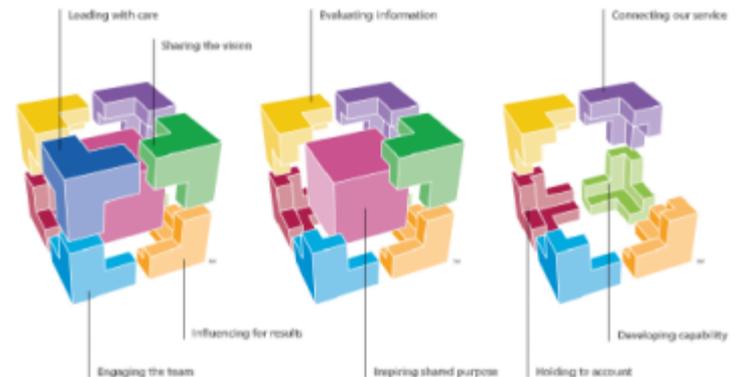
The programme comprises of 8 full days of study, facilitated by a range of external and internal speakers, held on a quarterly basis over 2 years. You will be expected to attend all 8 days and this time will not be deducted from your study leave allowance.

## CLINICAL LEADERS DEVELOPMENT PROGRAMME

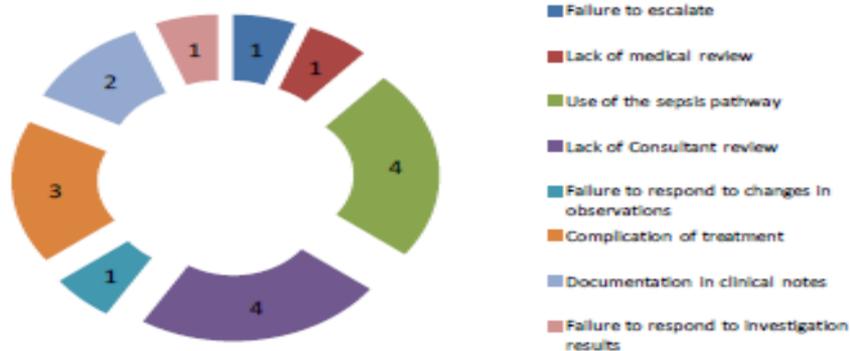
### Introduction To The Programme

The Clinical Leaders Development Programme 2014 - 2016 has been established in collaboration with Wirral University Teaching Hospital and the Countess of Chester Hospital:

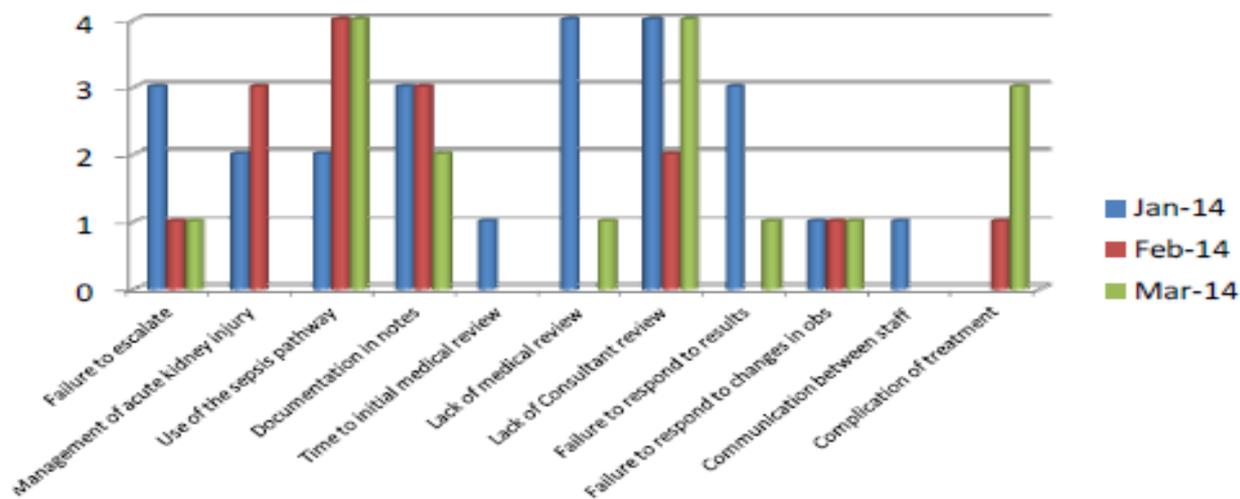
- To provide a supportive environment in which clinicians can develop and expand their leadership knowledge and skills, reflect on their capabilities and explore new ways of behaving.
- To allow those interested in clinical leadership to network and share best practice with other clinical and managerial colleagues both internally and externally to their organisation.
- To support the process of talent management and succession planning for clinical leadership roles.
- Around the 9 leadership dimensions in the new Health Care Leadership Model (2014).



## Areas for Improvement March 2014



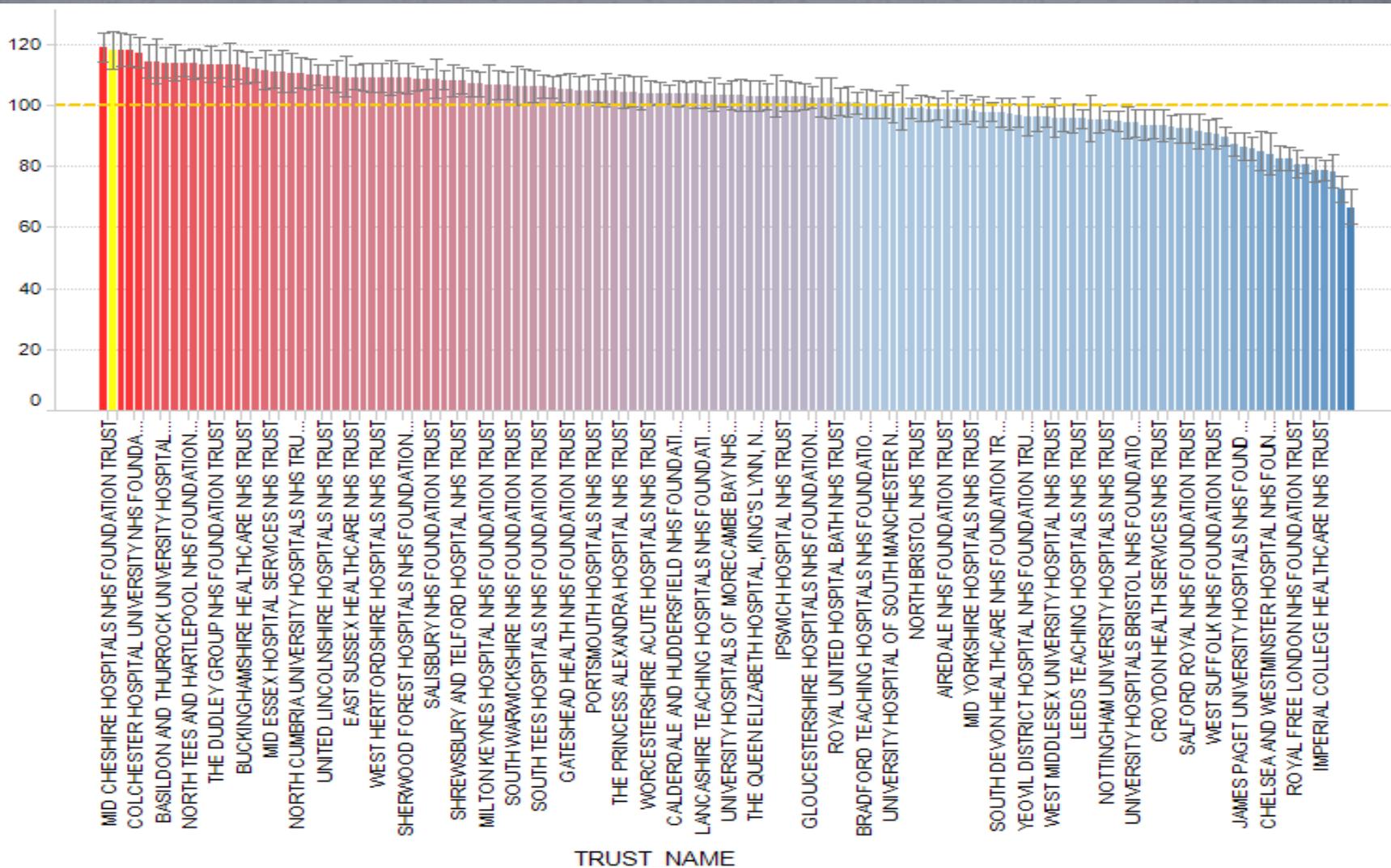
## Areas for Improvement 2014



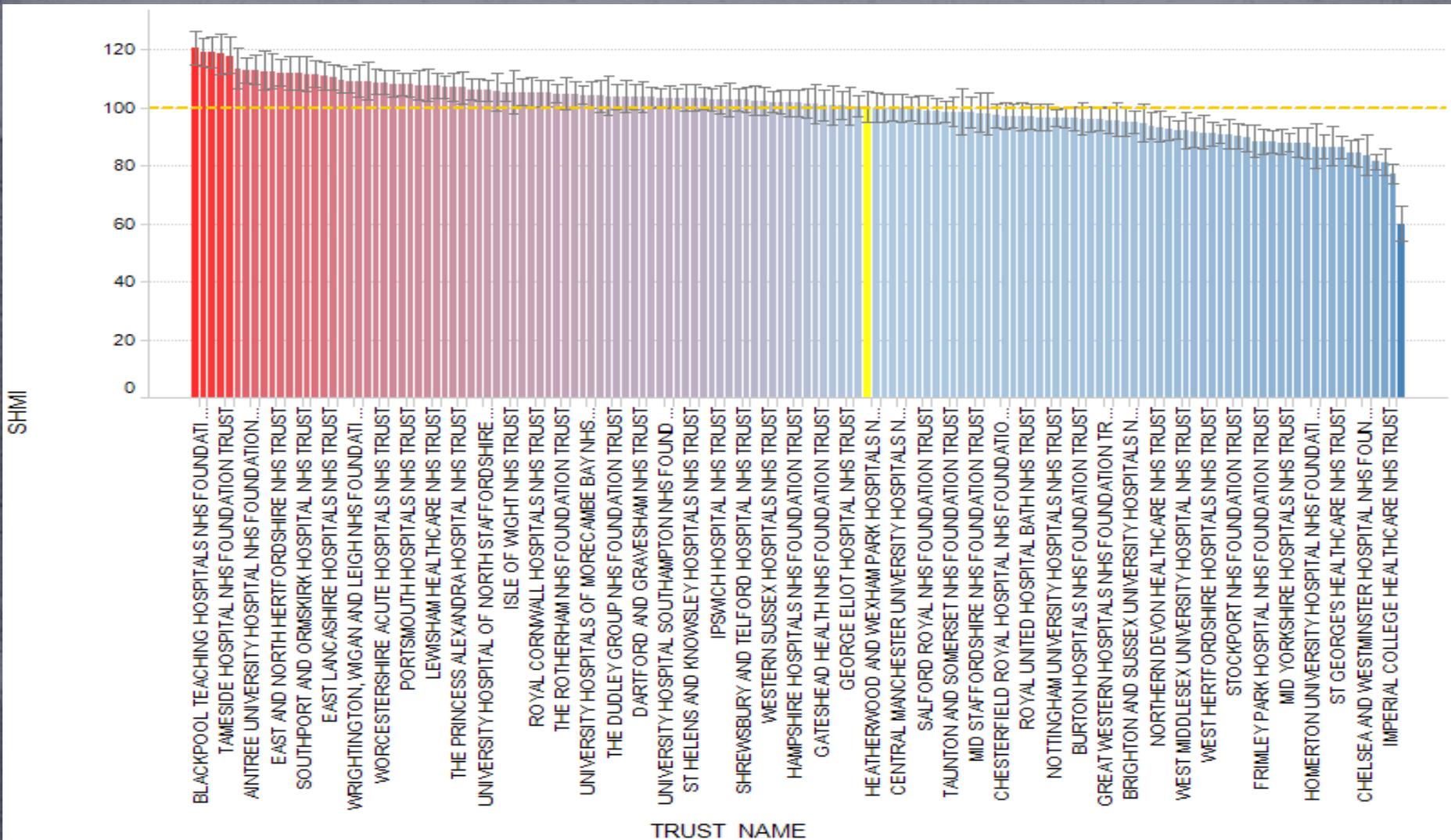


# SHMI (April 12 – March 13) = 1.16

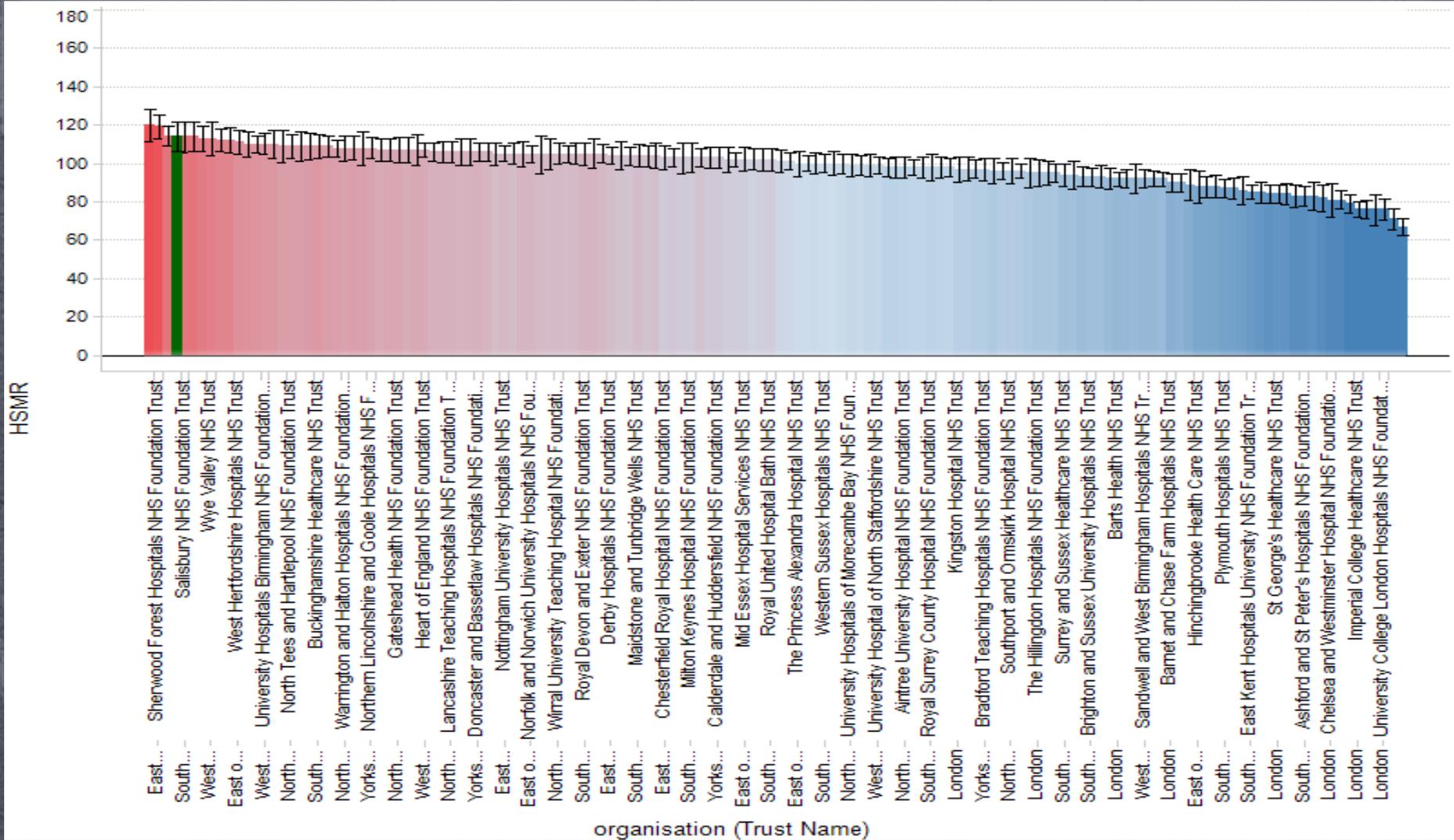
SHMI



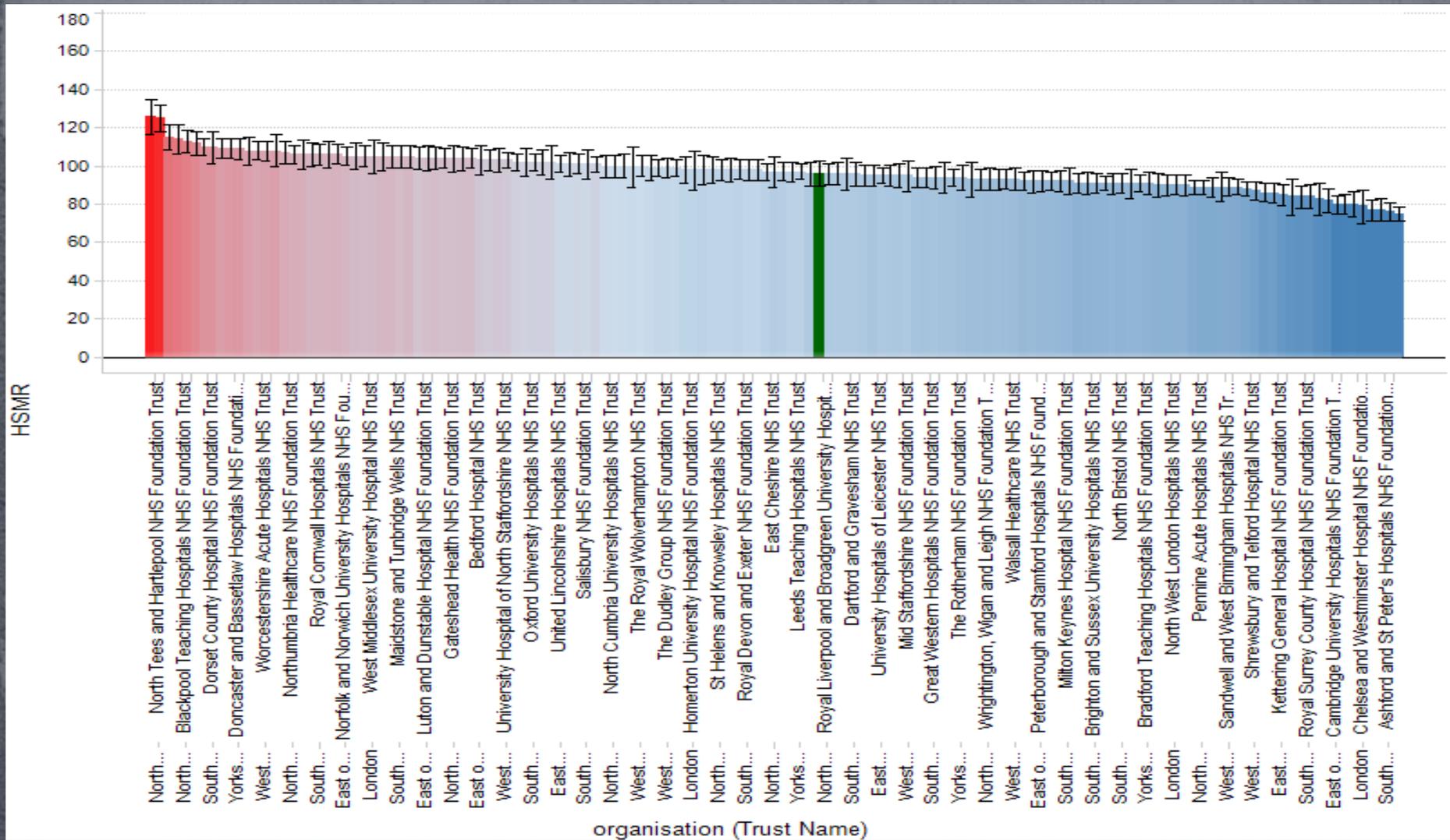
# SHMI (Oct 13 – Sept 14) = 1.00



# HSMR (April 12 – March 13) = 114.5



# HSMR (Oct 13 – Sept 14) = 98.9



# What Went Well

- Multidisciplinary organisational engagement / ownership
- Weekly case note reviews
- Mortality workshops
- Quality Improvement training / projects
- Clinical Leadership Development Programme

# What Could Have Gone Better

- Recruitment to “difficult to fill” posts
- Standard of medical documentation and state of the case notes
- Adherence to care pathways / bundles
- Engagement / ownership across the health and social care economy

# Next Steps

- Refresh our Quality and Safety Improvement Strategy
- Improve our recruitment capability
- Improve collaborative working with nursing homes
- Train cohort of primary / secondary care clinicians in quality improvement
- Undertake focused piece of work on signs / symptoms / co-morbidities in the “living”

# PANEL DISCUSSION AND REFLECTIONS

# LUNCH AND NETWORKING

# **WORKING GROUPS – DEEPER DIVE INTO DRIVER DIAGRAMMS**

AQUA Academy

# Driver Diagrams

## Driver Diagrams – why use them?

- Breaks down any broad aim into increasing levels of detailed actions that should or could be done to achieve the stated aim
- Helps focus on the cause and effect relationships that exist in complex situations.
- Well defined drivers can form the focus of improvement efforts.

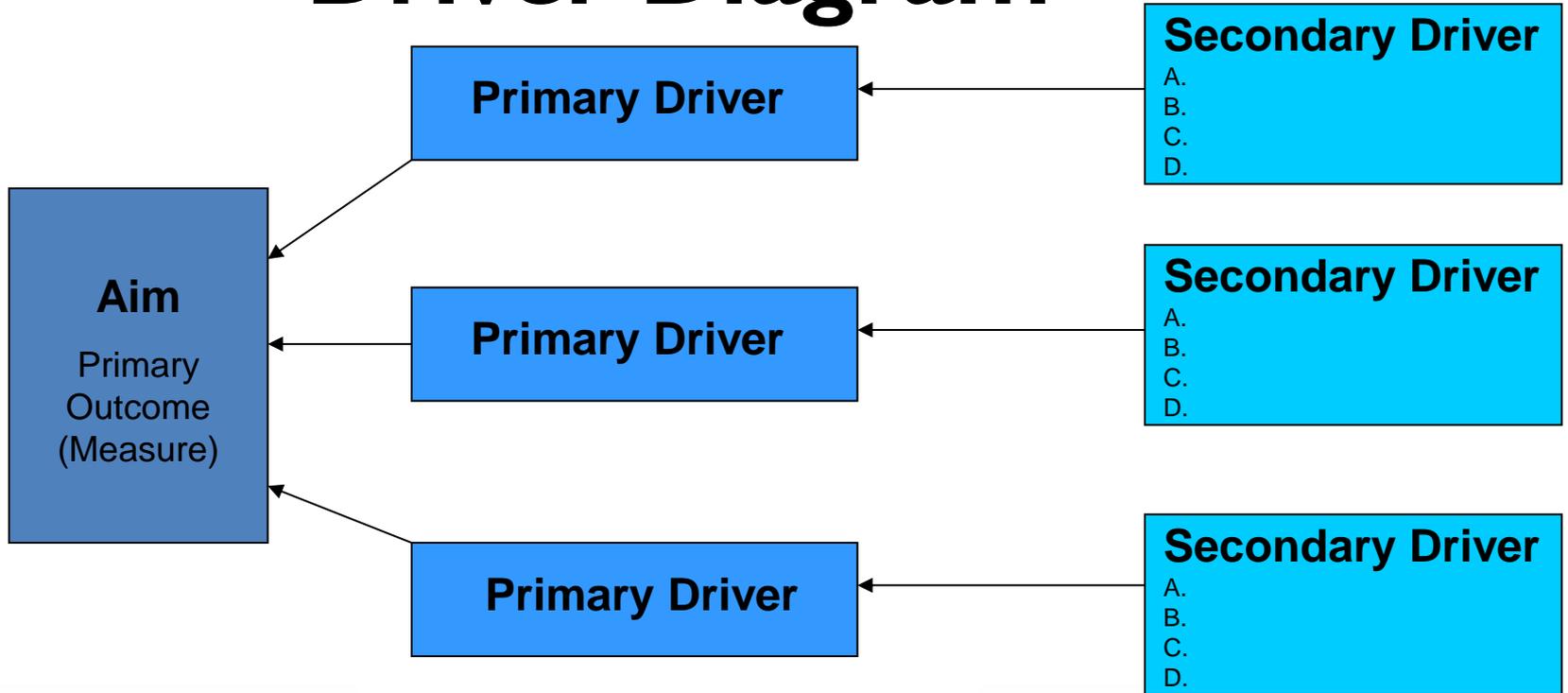
# What are the component parts?

- Aim or goal of your improvement effort. What are trying to achieve and by when?
- Primary drivers – key system components that contribute directly to the chosen aim or goal. Often processes, rules of conduct or structure that are described here
- Secondary drivers – elements/aspects within your primary drivers which can be used to create change projects. Often components and activities that are described here
- Relationship arrows - show the connection between the primary and secondary drivers. A single secondary driver may impact upon a number of primary drivers

## Developing driver diagrams

- Dedicate time for team and subject matter experts – ask them to come prepared!
- Revisit your aim statement
- Brainstorm potential Primary Drivers & check
  - **‘If I made an improvement in this driver what would it achieve?’**
  - **‘If I could influence (or improve) against all of these drivers is there anything else that could go wrong and prevent me achieving my aim?’**

# Driver Diagram



Primary drivers are system components which will contribute to moving the primary outcome.

Secondary drivers are elements of the associated primary drivers. They can be used to create projects or change packages that will affect the primary driver.

## Aim / Outcome

100% of patients with an official diagnosis of dementia with the contact details of a named carer on their record by December 2013

## Primary Drivers

Process to identify diagnosed patients

Identification of a named carer

System to record contact details

Considerations of information governance

## Secondary Drivers

Initial diagnosis made

Communication plan

Management plan

Agree and allocate named carer

Named carer informed

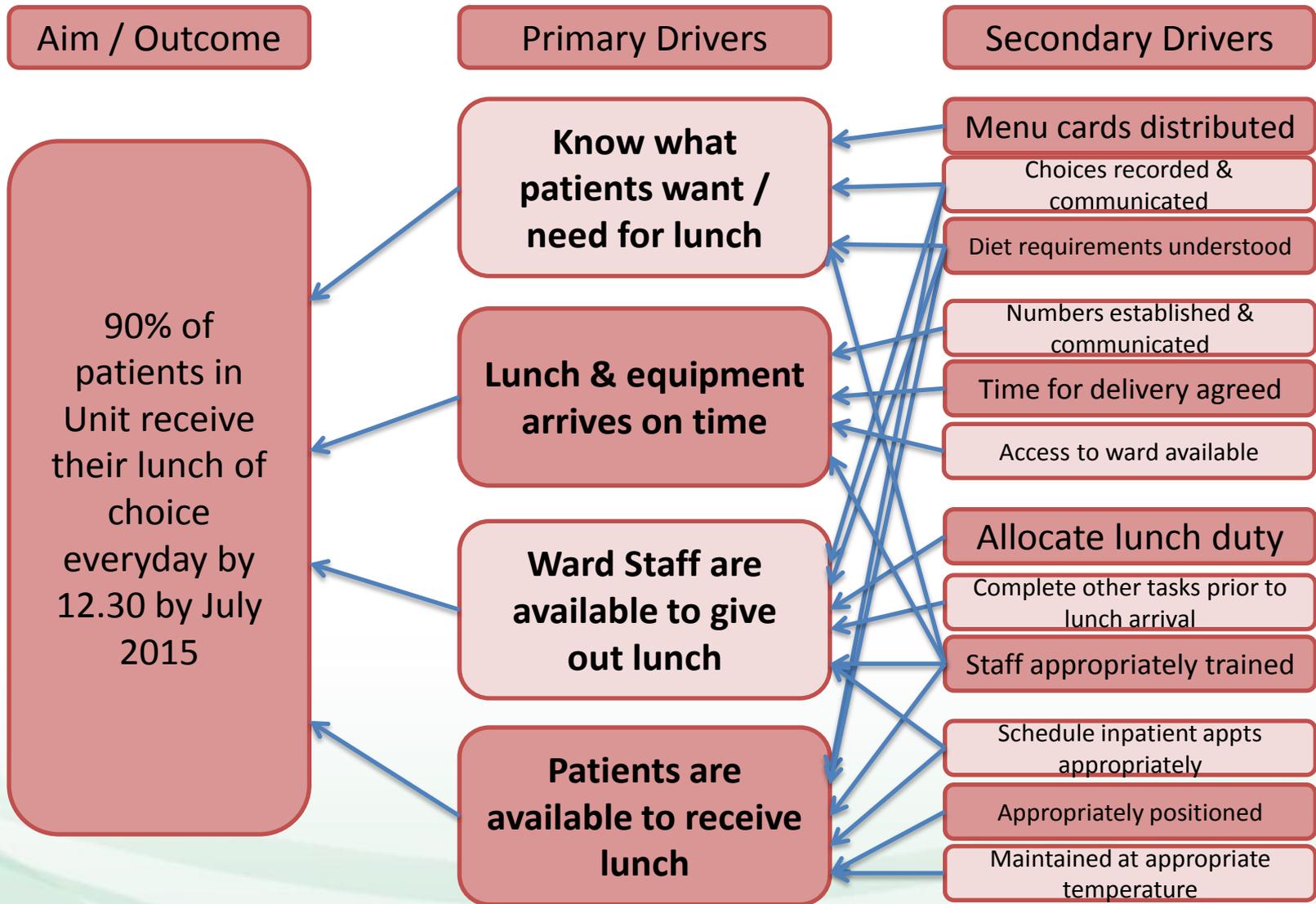
Who's responsibility?

Where is it recorded?

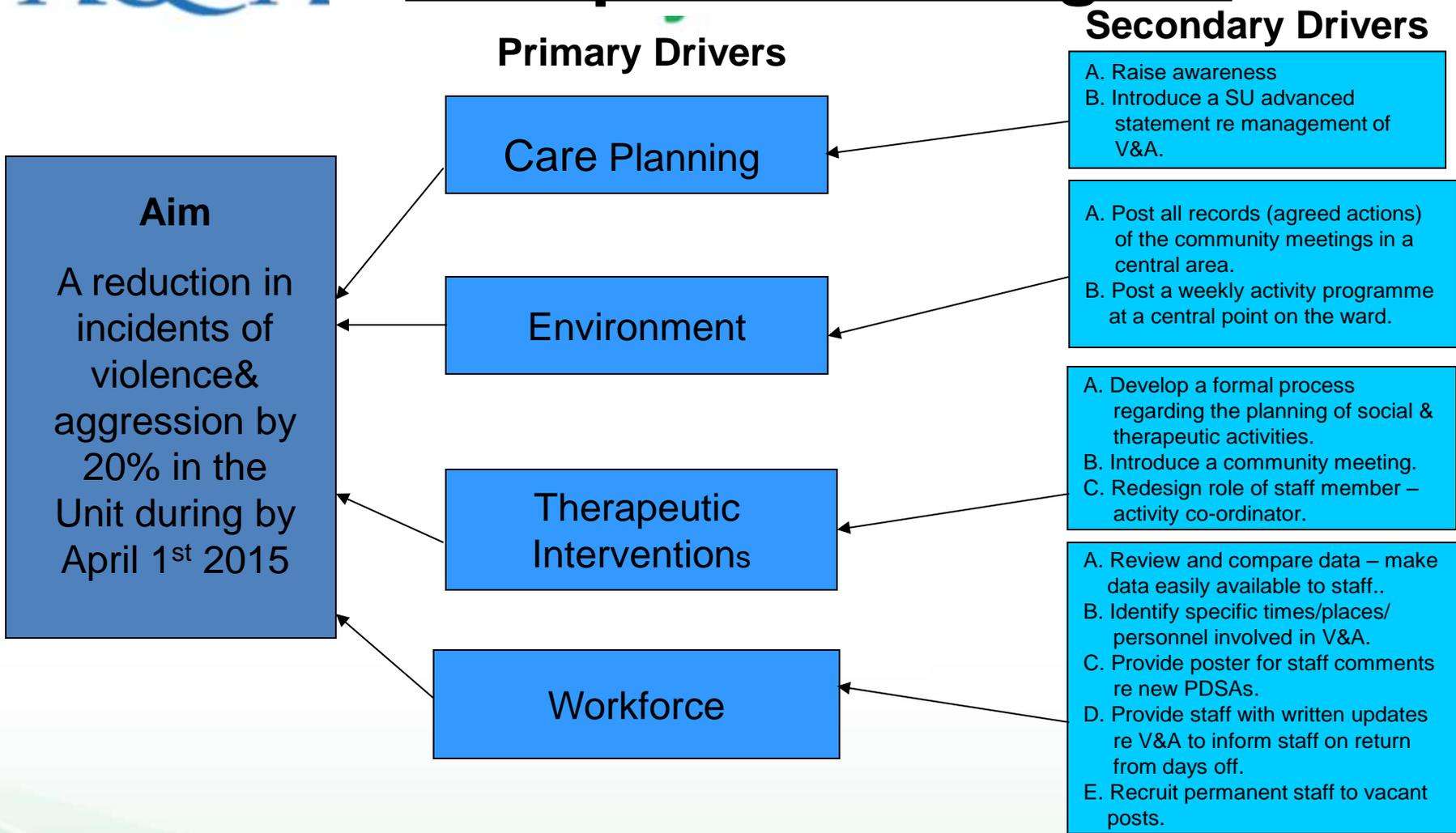
When is it reviewed?

Is patient happy to be identified?

Existing IG agreements



## Example: Driver Diagram



Primary drivers are the systems changes which will contribute to achieving the Aim outcome measure.

Secondary drivers are interventions associated with primary drivers. They can be used to create projects or change packages that will affect the primary driver.

- Driver diagrams are a 'live' tool. They change over time as you make changes to your project.
- If you can make your goal, drivers and project outcomes measurable you have created a measurement framework for determining progress. It will also help you to judge where more progress against a particular driver needs to occur.
- Creating a driver diagram with a team ensures that everyone understands your goal and how they can contribute towards achieving it.
- Get the right people there so that you have knowledge in the room from people who see all parts of the care process.
- A driver diagram is an improvement tool. Stop identifying additional layers of drivers when it ceases to be helpful (i.e. when your improvement projects start to become apparent). Be confident and prioritise your drivers by selecting quick wins or dismissing drivers that in reality have little impact.
- Don't automatically ignore drivers that seem outside of your control. Sometimes with some lateral thinking (or partnership working) you can influence them.
- Driver diagrams will vary - there is no definitive 'right' answer.

# FEEDBACK AND REFLECTION

# **WORKING GROUPS – BUILDING A DRIVER DIAGRAM FOR YOUR TRUST**

# FEEDBACK AND REFLECTION

# **DEVELOPING A MORTALITY LEARNING COMMUNITY – OPEN DISCUSSION**

**CLOSE**