

Hospital Mortality Summit

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Mortality Monitoring & Reducing Avoidable Deaths attributable to problems in care: Where are we now?

Thursday 20 October 2016

Hallam Conference Centre London



Speakers include

Dr Helen Horgan
Clinical Lecturer in UK Public Health
London School of Hygiene
& Tropical Medicine

Chris Dew
*Clinical Indicators
Programme Manager*
The Health and Social Care
Information Centre

Dr Alan Fletcher
*Medical Examiner
& Consultant in Acute
& Emergency Medicine*
Sheffield Teaching Hospitals
NHS Foundation Trust

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Mortality Monitoring & Reducing Avoidable Deaths attributable to problems in care: Where are we now?

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This national Summit will focus on the question of mortality monitoring: where are we now? Through national updates and practical case studies the conference will look at how we can reduce and monitor avoidable deaths in hospitals through a range of measures which will replace the single hospital wide HSMR approach. The various approaches will aim to answer the question of whether a problem in care contributed to death, and how to identify which deaths attributable to problems in care are unavoidable. Areas covered will include mortality audits, internal inspection, mortality reviews, case note reviews, early identification of care problems, the patient voice as an early warning system and the role of mortality monitoring for individual consultants.

The conference will look at the latest evidence on avoidable deaths, including the topical issue of mortality at weekends.

"Trusts will have to carry out a self-assessment of avoidable mortality to help create a new organisation level "avoidable deaths" figure."

HSJ 2016

"Avoidable mortality is based on the concept that premature deaths from certain conditions should be rare, and ideally should not occur if there are timely and effective healthcare or public health interventions." Department of Health 2016

"I want all hospital boards to have a laser-like focus on eradicating avoidable deaths in their organisation; even one life lost to poor care or safety error is too many"

Jeremy Hunt, Minister of State for Health

"Mortality statistics require careful interpretation, but they do provide an important smoke signal....by following the smoke and carrying out proper, transparent analysis and supporting as necessary, you can help hospitals make significant improvements."

Prof Sir Bruce Keogh, national medical director, NHS England

10.00 Chairman's Welcome and Introduction

Dr Martin Farrier

Medical Director for Quality & Consultant Paediatrician
Wrightington, Wigan and Leigh NHS Foundation Trust

10.10 Mortality Monitoring: Where are we now and what is the evidence?

Dr Helen Hogan

Clinical Lecturer in UK Public Health/Course Director
London School of Hygiene and Tropical Medicine

- mortality monitoring: where are we now?
- measuring avoidable deaths: case note review and hospital-wide mortality ratios
- looking forward: new ways to look at harm, mortality and avoidable deaths
- engaging clinicians in assessing the safety of their care to stimulate improvement
- an update on the national mortality review programme

10.40 Estimating the risk of mortality in hospital patients

Chris Dew

Head of Clinical Indicator Development
The Health and Social Care Information Centre

- the calculation of the Summary Hospital level Mortality Indicator (SHMI), which is published quarterly by the HSCIC and is used to identify whether the number of deaths which have occurred among hospital patients is more or less than expected.
- using this information to reduce mortality rates

11.10 Questions and answers, followed by coffee and exhibition

11.50 EXTENDED SESSION: Developing the role of mortality audits, internal inspection and mortality reviews to answer the question "did a problem in care contribute to the death?"

Dr Martin Farrier

Medical Director for Quality & Consultant Paediatrician

with Alison Unsworth

Clinical Coding Lead - Division of Medicine & Deputy Clinical Coding Manager
Wrightington, Wigan and Leigh NHS Foundation Trust

- implementing a weekly mortality audit, and generating learning and systematic quality improvements from the problems identified
- identifying and focussing on priority areas for meaningful improvement
- using mortality review to engage clinicians in quality improvement
- feeding back the results to clinicians to change practice

13.00 Question and answers, followed by lunch and exhibition

14.00 Reducing weekend mortality: what works?

Simon Swift

Director
Methods Consulting Limited

- what is the "weekend effect"?
- weekend mortality: is there a staffing issue?
- what is the evidence, and why is there disagreement on weekend mortality?
- what works to reduce mortality at weekends?

14.30 How do we identify which deaths are attributable to problems in care and therefore avoidable? The Medical Examiner system and mortality case note review

Dr Alan Fletcher

Consultant in Acute and Emergency Medicine
Sheffield Teaching Hospitals NHS Foundation Trust
and Medical Examiner for HM Coroner South Yorkshire (West)

- understanding the root cause of avoidable deaths, ensuring independent review and correct referral to the coroner
- understanding which deaths are attributable to problems in care at a local level: carrying out mortality audits and case note review to identify the potential for future harm
- where to focus your improvement efforts?
- establishing cause of death and improving the system for death certification
- how will we measure the impact of the changes?

15.00 Question and answers, followed by Tea and exhibition at 15.30

16.00 Early identification of care problems to reduce mortality

Dr Jane Burns

Divisional Medical Director (Acute)
NHS Lanarkshire

- how do we ensure rapid identification of unsafe care?
- what did we learn from the Keogh mortality reviews?
- understanding the reasons for outliers and engaging clinicians
- the link between mortality and quality
- how do we ensure early identification of problems to reduce mortality

16.30 Patient and Public Voice as Early Warning Systems: Acting on Patient and Carer Concerns

Dr Josephine Ocloo

Patients for Patient Safety Champion, England
WHO Patient Safety Programme

- ensuring systems are in place to ensure patient and carer concerns are heard
- developing a culture of open and honest cooperation
- patient and public involvement for patient safety

17.00 Chairman's Closing Remarks, Question and answers, followed by close

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The PDF will be emailed out after the conference, please fill in the 'Your Details' section above, ensuring your email address is clear and the 'Payment' section..

For more information contact Healthcare Conferences UK on **01932 429933** or email **Jayne@hc-uk.org.uk**

Venue

Hallam Conference Centre, 44 Hallam Street
London, W1W 6JJ. A map of the venue will be sent with confirmation of your booking.

Date Thursday 20 October 2016

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
☐ £300 + VAT (£360.00) for voluntary sector / charities.
☐ £495 + VAT (£594.00) for commercial organisations.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

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