Reducing & Monitoring Avoidable Hospital Deaths attributable to problems in care

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Hospital Mortality Monitoring: Where are we now?

Thursday 21 May 2015 **Colmore Gate, Birmingham City Centre**

Chair and Speakers include

Dr Martin Farrier
Medical Director for Quality
Wrightington, Wigan and Leigh NHS Foundation Trust

Dr Sharon Mayor
Senior Lecturer in Healthcare Improvement
Cardiff University

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

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Hospital Mortality Monitoring: Where are we now?

Thursday 21 May 2015 **Colmore Gate, Birmingham City Centre**

This conference will focus on Mortality Monitoring: where are we now?
Understanding how to measure and avoid unnecessary deaths in Hospital

"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, 8th February 2015

Labour said it would "look at the detail, but from what we have seen this does not appear ambitious enough". It added it was "looking at whether we can go further and have a mandatory review of case notes for every death in hospital - not just for a sample of cases as Jeremy Hunt proposes". BBC News 8th February 2015

Prof Nick Black, at the School of Hygiene and Tropical Medicine has been leading a national review of mortality commissioned by Sir Bruce as part of the recommendations set out in the Keogh review. The original review, carried out by Sir Bruce Keogh, was published last year and looked at the quality of care and treatment at 14 hospital trusts in England. The hospital trusts were selected for the Keogh review based on either the Hospital Standardised Mortality Ratio (HMSR) or the Summary Hospital-Level Mortality Index (SHMI), which were used to flag up hospitals where apparently unusually high numbers of patients are dying. In the review. Sir Bruce set out eight 'ambitions' for improvement to tackle some of the underlying causes of poor care. One of these ambitions will see Prof Black, along with Prof Lord Ara Darzi from Imperial College London, carry out the study into the relationship between excess mortality rates and actual avoidable deaths. The report stated that this study will pave the way for the introduction of a new national indicator on avoidable deaths in hospitals, measured through the introduction of systematic and externally audited case note reviews. The study was due to report its findings in December 2014.

Prof Nick Black recently spoke about why hospital-wide mortality ratios should be avoided and what should replace them. This conference 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.

"I don't set much store by these hospital standardised mortality ratios. The good news is that we must still look at mortality and there is another way of doing it and that is to do case note reviews, by which I mean we look in great depth at each and every death in a hospital; we get clinicians, physicians to do this who have been specially trained, using all the standardised techniques, and from that we can determine what proportion of deaths are avoidable.It's a time consuming process but there's immediate benefits to the clinicians because they learn things about their own hospital and their own care." Prof Nick Black, Lead, Study into Avoidable Deaths, & Professor of Health Services Research, London School of Hygiene and Tropical Medicine

Follow this conference on Twitter #avoidablemortality

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?**

Dr Sharon Mayor
Senior Lecturer in Healthcare Improvement
Cardiff University

- mortality monitoring: where are we now?
- should hospital-wide mortality ratios be avoided?
- looking forward: new ways to look at harm, mortality and avoidable deaths
- engaging clinicians in assessing the safety of their care to stimulate improvement

10.55 **Estimating the risk of mortality in hospital patients**

Chris Dew
Head of Clinical indicator Development
The Health and Social Care Information Centre

- this estimation underpins 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

11.25 *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
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 **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?

14.30 **Early identification of care problems to reduce mortality**

Dr Umesh Prabhu
Medical Director
Wrightington, Wigan and Leigh NHS Foundation Trust

- 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

15.00 **The Patient Voice as a Early Warning System: Early Warning Systems: Acting on Patient and Carer Concerns**

Patient Representative

- 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
- working with families to learn from Mid Staffordshire

15.30 *Question and answers, followed by Tea*

16.00 **Monitoring and reducing mortality and improving outcomes at individual consultant level**

Steve Mackenney
Founder
Crab Clinical Informatics

- consultant level data publication
- understanding avoidable mortality data at individual consultant level
- the role of PROMs in measuring and improving outcomes
- a step by step guide to tools which can act as early warning systems
- ensuring clinical outcomes and quality indicator monitoring links to performance monitoring: would your clinical outcomes monitoring pick up deteriorating performance or increased mortality?
- developing trigger points within monitoring systems

16.30 **Using internal inspection and monitoring to improve standards**

Simon Swift
Director
Methods Insight Analytics

- monitoring and auditing of hospital deaths
- setting up a process of "internal inspection" along the lines of Keogh, making changes, to maintain standards, and assure that they are maintained even when the CQC and others aren't looking
- HSMR and early warning systems: what have we learnt and what do we need to change moving forward?

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

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Date Thursday 21 May 2015

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