Reducing & Monitoring Avoidable Hospital Deaths attributable to problems in care

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Hospital Mortality Monitoring: Where are we now?

Thursday 8 October 2015 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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"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

The current government have recently announced an annual review into avoidable deaths, *"the review will be used to establish a national rate of avoidable deaths every year, and on that basis place individual hospitals into bandings according to the number of deaths estimated locally"* said a Department of Health spokeswoman in February 2015. In response, Mortality Rates Expert Prof Nick Black stated that *"A national annual review would place England as the first country in the world to monitor the extent of avoidable deaths, and provide a basis for stimulating quality improvement in each individual hospital."*

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 Sir Bruce Keogh, national medical director, said: ***"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." February 2015***

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

- 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
- the national annual review of avoidable deaths

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
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 **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**

Professor Elizabeth Robb
Member, National Advisory Group, Hospital Mortality Review
& Chief Executive, Florence Nightingale Foundation

- 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**

Peter Walsh
Chief Executive
Action against Medical Accidents (AVMA)

- 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

15.30 *Question and answers, followed by Tea*

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

Mr Graham Copeland
Consultant General Surgeon
Warrington and Halton Hospitals NHS Foundation Trust

- 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 Consulting Limited

- the CQC mortality outliers programme
- monitoring mortality trends: what signals an alert to the CQC
- 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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Venue
Hallam Conference Centre, 44 Hallam Street
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Date Thursday 8 October 2015

Conference Fee

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