

Hospital Mortality Summit

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Reducing & Monitoring Avoidable

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

Wednesday 22 February 2017 The Studio, Birmingham



Conference Chair & Speakers Include

Dr Martin Farrier

*Medical Director for Quality &
Consultant Paediatrician*

*Wrightington, Wigan and Leigh NHS
Foundation Trust*

Chris Dew

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

Supporting Organisation



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Reducing & Monitoring Avoidable 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. The conference will also update delegates on the findings of the CQC review of how NHS trusts investigate and learn from deaths which is due to be published in December 2016.

"Trusts will have to carry out a self-assessment of avoidable mortality to help create a new organization 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 Chairs Welcome & Introduction

Dr Martin Farrier *Medical Director for Quality & Consultant Paediatrician* Wrightington, Wigan and Leigh NHS Foundation Trust

10.10 Mortality Reviewing in Wales: what have we learned?

Dr Jason Shannon

Consultant Histopathologist and Assistant Medical Director Pathology
Cwm Taf University Health Board

- The story of implementing an All Wales System
- Who do you need on board?
- What the numbers don't tell you
- The future model and direction for Wales

10.40 Learning from the investigation of deaths review: supporting learning and driving improvement

Representative (invited)

Care Quality Commission

- findings and learning from the CQC review into investigations of deaths in NHS Trusts
- implementing the CQC recommendations on serious incident investigation
- what should be reported to CQC
- the CQC role in mortality monitoring
- moving forward...

11.10 Question and answers, followed by tea & coffee at 11.20

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

Clinical 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

12.50 Question and answers, followed by lunch at 13.00

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 Estimating the risk of mortality in hospital patients

Chris Dew

Clinical Indicators Programme Manager
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

15.00 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
& Medical Examiner
HM Coroner South Yorkshire (West)

- understanding the proposed new medical examiner system and how it will integrate with existing systems
- 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 using information from medical examiners
- establishing cause of death and improving the system for death certification
- how will we measure the impact of the changes?

15.30 Question and answers, followed by tea & coffee at 15.40

16.00 Early identification of care problems to reduce mortality

Prof Steve Powis

Medical Director
Royal Free Hampstead NHS 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

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

Phil Stylianides

Director of Commercial Strategy, Marketing and Communications
Picker Institute Europe

- 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 Question and answers, followed by close at 17.10

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Venue

The Studio, 7 Cannon Street, Birmingham, B2 5EP. A map of the venue will be sent with confirmation of your booking.

Date Wednesday 22 February 2017

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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