Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

GP briefing note on mortality rates at the Northern Devon Healthcare NHS Trust

Foreword

We are circulating this briefing note because we can understand how recent reports about mortality rates at the Trust would be of concern to patients and GPs.

Whilst I can state with a substantial degree of certainty that we do not have an issue at the Trust which means more patients die than would have been expected, I do not expect you to take this statement at face value.

Therefore, the following briefing note explains when we noticed an issue, what the data shows, what we did to understand the data, what actions we took and the outcomes that we look at which lead us to be confident in the view that our care is safe and of a high quality.

From the timeline, you will see that I made it my business to understand the data and act as soon as I saw a worrying trend.

The mortality rate compares our Trust directly with acute-only Trusts.

Mortality ratios/indices are a very useful clinical tool for spotting areas of concern and scrutinising whether there is an underlying safety issue at hospital or ward level or with regards to a particular clinician or team. Whilst it does not tell you where the area of concern is, our Trust's approach was to prioritise effort in the areas which posed the greatest potential harm to patients.

We have acted and our position is now improving. We have asked NHS South West to audit our actions and progress on mortality rates to ensure we are doing all we can and to provide reassurance to the wider health community that our care is safe and of a high quality.

As we go through our Foundation Trust bid, we are experiencing considerable scrutiny of our performance data, particularly mortality rates. We have involved our commissioners continually through regular reporting and discussions at monthly Clinical Quality Review meetings (CQRM). We also expect that the commissioners will ask us to comment further on our mortality data following the Francis Report.

What follows is a more detailed briefing so you can fully understand the approach we took and the successful outcomes we can demonstrate. I hope that this information ensures you are in a position to form your own views and I welcome any comments or requests for further clarification.

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The Northern Devon Healthcare NHS Trust runs NDDH in Barnstaple, a 300-bed acute, and 17 community hospitals with 320 beds.

Our mortality data for the last 12 months is as follows:

Trust overall HSMR	**106.4**
NDDH HSMR	**95.6**
Northern Community Hospitals HSMR	**103.2**
Eastern Community Hospitals HSMR	**121.5**
Trust-wide SHMI	**100**

Timeline

October to December 2010

The Board scrutinises the mortality data every month. We identified an issue with our mortality rates in October 2010. After dipping back to normal in November, we saw another rise in mortality rates in December.

January 2011

This increased rate sustained into January 2011 and the Medical Director launched an investigation, lasting two years, to understand the reasons for the higher mortality rates and prioritising the actions required.

2011/12

Investigation

- 200 patient case notes were peer reviewed by senior consultants across acute and community. No areas of obvious concern were identified.
- Our Dr Foster Intelligence Support Team invested significant time to help us better understand the data.
- We reinforced with our staff the need to fully document initial assessments and comorbidities (to ensure these factors were reflected in coding).
- We subsequently identified a shortfall in our recording of patients receiving palliative care, which can contribute to a higher than expected Hospital Standardised Mortality Ratio (HSMR).
- We established that HSMR was designed as an acute mortality indicator, which does not translate well to community hospital inpatients.
- We have carefully tracked our Summary Hospital-level Mortality Indicator (SHMI) ratio and were able to see that this (DH preferred) indicator showed our overall mortality ratio to be below the national average.
- We also tracked our crude mortality rates (deaths as a proportion of hospital spells) and this did not reveal any concerns.

Concurrent patient safety drives across the Trust

Mortality data is an index or ratio of several factors about clinical care and outcomes. Our patient safety strategy was to focus on the most likely causes of a higher mortality ratio, ie those areas where avoidable harm could be prevented. We took considerable action to ensure that there were no underlying clinical concerns.

The patient safety drives are all described in the diagram on page 4.

These were also all articulated in our 2012/13 Quality Account.

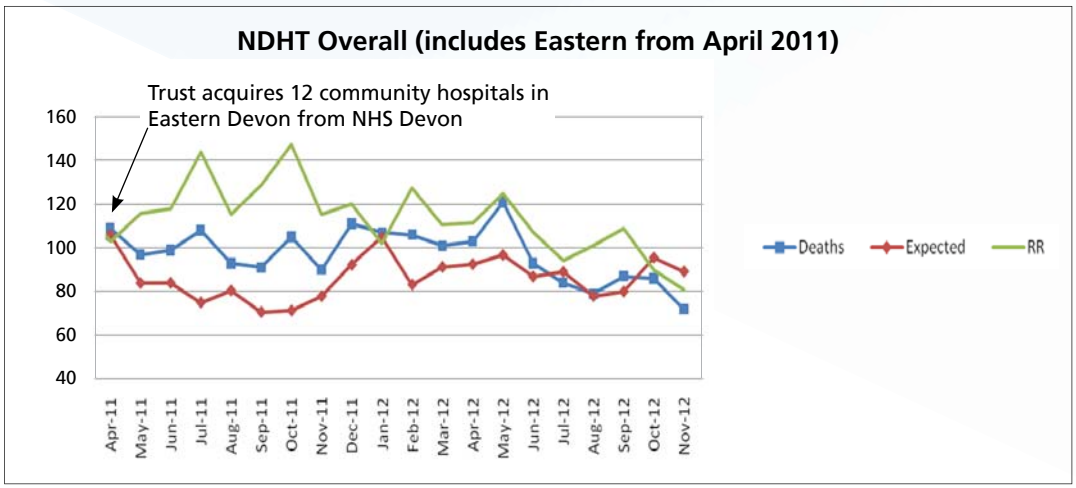
January 2013

Outcomes

The actions we took have combined to reduce our mortality rate and the rolling 12-month measure continues on a downward trajectory month by month.

The purpose of this briefing note is to provide all our GP colleagues, whether they are principally commissioners of our services, referrers into our services or employees in our community hospitals, access to some key reference information about our response to fluctuations in our mortality rates.

The data



Mortality data and its role as an early-warning indicator of possible concerns with the quality of health services are becoming increasingly useful to clinicians working in health services.

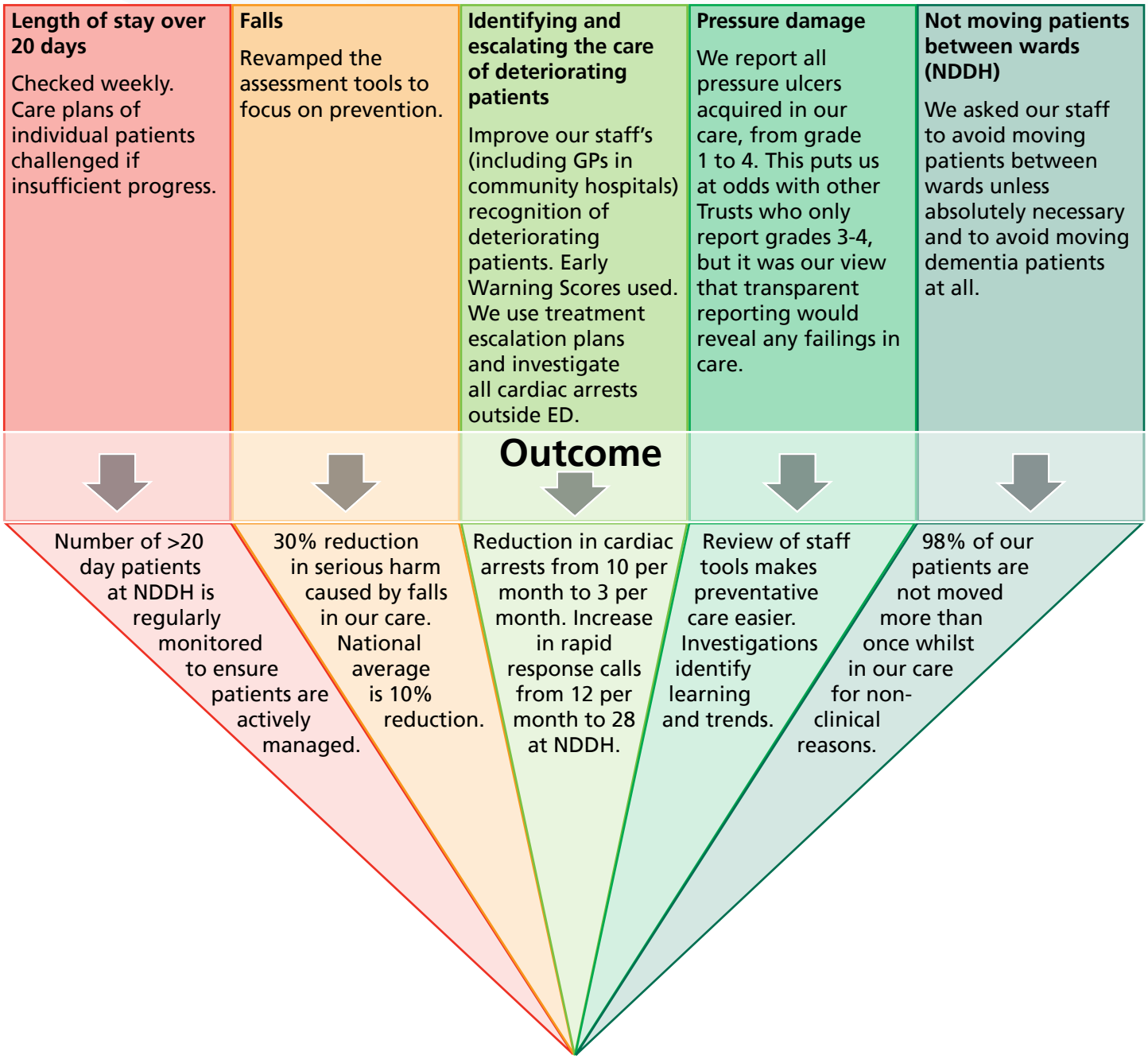
All the national mortality ratios and indices for the Trust aggregate the data for NDDH and the 17 community hospitals, despite being very different clinical environments.

At the time of writing, our mortality data is as follows:	
HSMR	
Trust-wide	106.4
NDDH	95.6
Northern Community	103.2
Eastern Community	121.5
SHMI	
Trust-wide	100

Our response to patients

These are some of the initiatives that we launched in our drive to ensure high-quality care.

The graphic below describes how we used mortality data to triangulate our approach. Each area has been the focus of significant management scrutiny to ensure that we achieved demonstrable progress.



All these have worked to bring the mortality rate down.

HSMR

Coding

It is important that we assess patients accurately and that the care is translated into coded episodes of care. The consequence of not doing this is that it appears our population is healthier than public health data on demography would suggest, we do fewer procedures and have a higher risk of mortality.

We have worked with our junior doctors and consultants to reinforce the importance of early primary diagnosis, especially during emergency and MAU admissions.

Following new national guidance in August 2010, we were slow to amend the way we recorded the intervention of specialist palliative expertise in the patient's episode of care. We were not alone in this, but worked to address it quickly once the issue was identified. Palliative coding has been steadily improving across the Trust, but will take a long time to filter through to the mortality data.

Our outcomes

The proof is in the pudding.

The recently-published NHS Safety Thermometer shows that the Northern Devon Healthcare NHS Trust has the fourth most improved performance in England in terms of reducing avoidable harm caused to patients. This was featured in the Health Service Journal on 7 February 2013.

The Care Quality Commission conducted an unannounced inspection last week and visited 10 of our wards speaking to 68 patients, 63 staff and 18 visitors/carers. Their informal feedback was that they received a warm welcome, with staff inviting the inspectors to come and see their wards or services.

The last day of the visit coincided with publication of the Francis report on Mid Staffordshire. The inspectors immediately took the opportunity to test awareness of the report and to ask staff how they would respond to some of the key issues, such as raising incidents of poor care within the Trust. The unanimous response from our staff, according to the inspectors, was that people wouldn't want patients at NDDH to be in the same situation as at Mid Staffs.

The inspectors advised us that we were fully compliant with all five outcomes. Their report will inevitably identify areas for improvement, but these are expected to be minor.

Last week, we also had a dementia peer review by the team from Derriford Hospital. The feedback from the team was that they were blown away by what we were doing for our patients with dementia. They were also really impressed by the project we were working on with The King's Fund, which you can view on our website.

Definitions

Our performance has been benchmarked against three mortality ratios, two of which are more commonly used than the third.

1. **HSMR:** Dr Foster uses the Hospital Standardised Mortality Ratio. This is published in the annual Dr Foster Hospital Guide. For the purposes of data collection, Dr Foster's definition of death in hospital takes into account terminally ill patients, receiving palliative care.

   Early indications of the data that would appear in the Dr Foster Hospital Guide 2012 were given to us in August 2012. It was immediately clear that we might be an outlier for HSMR at 117.9 for 2011/12. We anticipated that on publication, our mortality data would cause concern.

   Splitting the data feeds between acute and community shows the disproportionate impact the community hospitals have on our Trust-wide mortality data.

   Over the previous 12 months, we had meetings with our Dr Foster support colleagues at which our concerns about the Trust's relative HSMR position have been emphasised. We have explored every avenue of investigation suggested by Dr Foster and this has contributed to the improvement trend highlighted.

   Over half of our beds are community hospital inpatient beds and Dr Foster recognised that the unique configuration of Trust services influenced the HSMR data.

2. **SHMI:** The Department of Health favours the Summary Hospital-level Mortality Indicator

   Our SHMI result has been consistently just below 100, and has never been above 100 since the measure was introduced. This is in the 'as expected' banding. SHMI does not rely on the recording of palliative care.

   At one point we had a gap of 20 points between the two measures of mortality, which was exceptional. We have worked extensively with the Dr Foster team to try to understand this difference.

   Whilst SHMI is the NHS/DH recognised mortality measure, the Trust Board still wished to understand why HSMR data indicated high mortality.

   Our joint view is that it appears to relate to the way patients at the terminal phase of their illness are statistically recorded.

3. **Professor Brian Jarman:** Brian Jarman published some data on his personal website which then formed the basis of an article in the Sunday Telegraph. This showed the Trust as having the highest mortality rate in England, along with RD&E.

   Both Trusts challenged the premise of this article and Dr Foster has distanced itself from it sending the following statement to the Sunday Telegraph.

   Response to story "The hospitals where too many patients die" in Sunday Telegraph 27/01/2013

   The figures referenced in The Sunday Telegraph by Laura Donnelly on 27/01/2013 were published independently of Dr Foster by Professor Brian Jarman on his personal website.