Health Scrutiny and Performance Panel

Agenda Item No. 5

24 JULY 2012

Walsall Clinical Commissioning Group Project Plan for Reducing Hospital Mortality Ratios at Walsall Healthcare Trust (WHT)

Ward(s) All

Portfolios: Cllr B. McCracken – Social Care and Health

Report:

The Walsall Clinical Commissioning Group (CCG), as the local leader of the local health system has responsibilities to provide assurance that health services are delivering safe, high quality care for their population. Public and patient representatives have every right to scrutinise, understand and ensure the commissioners and providers are taking all necessary steps deliver high quality care and patient safety in hospital, including reducing avoidable deaths in hospital.

Hospital mortality ratio indicators require close scrutiny to ensure that deaths in hospital are not an indicator of poor quality or inappropriate care. Whilst there are limitations on the use of hospital mortality statistics, all efforts should be made to fully understand the underlying contributing factors and the effective activities required to ameliorate mortality rates.

Where death is unavoidable all steps should be taken to ensure patient choice in place of death is ascertained and choice facilitated by all providers in the end of life care pathway.

The Strategic Health Authority monitors mortality at all Trusts within Midlands and the East of England. The SHA report generated in February 2012 (six months data) showed the ratio for Walsall Healthcare Trust as higher than expected at 118. The provider Trust is implementing an updated action plan aimed at reducing the HSMR. This is being monitored by the SHA and has been reviewed by the Black Country PCTs Cluster. The latest available report (for March 2012) shows a ratio of 102.

HSMR is an indicator in use for a number of years, which is a result of a complex mix of contributing factors. These include:

- Case Mix (how severely ill patients are when admitted to hospital)

- Hospice availability for those at the end of life
- Quality of care provided in admitting hospital
- Lifestyle choices of patients (e.g. smoking status)
- Disease coding
- Choice in preferred place of death

The CCG in conjunction with the Black Country PCTs Cluster has taken a number of actions in the past 12 months to both understand the rates and to assess the underlying contributing factors to local HSMRs.

In addition, the CCG has worked with the SHA to assess the quality of care provided in key specialties and departments at the hospital. For example, the appreciative enquiry visit undertaken in March 2012. Work has also been done to explore the underlying factors contributing to the HSMR, to work collaboratively with other medical directors across the region to improve the quality of clinical care and to improve the standard of care in our Nursing Homes, with specific training provided in the assessment and management of specific conditions in their residents.

The CCG is now in a position to put this intelligence into a more cohesive action plan for tracking, reviewing and reducing HSMR in Walsall.

This project plan details the next steps across the health economy to reduce hospital mortality ratios.

Recommendations:

That:

- the project brief outlined below be supported
- the project plan for reducing hospital mortality rates be supported

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NHS Walsall

Walsall Clinical Commissioning Group

Project Plan for Reducing Hospital Mortality Ratios at Walsall Healthcare Trust (WHT): 17 July 2012

1 Introduction

The Walsall Clinical Commissioning Group (CCG), as the local leader of the local health system has responsibilities to provide assurance that health services are delivering safe, high quality care for their population. Public and patient representatives have every right to scrutinise, understand and ensure the commissioners and providers are taking all necessary steps deliver high quality care and patient safety in hospital, including reducing avoidable deaths in hospital.

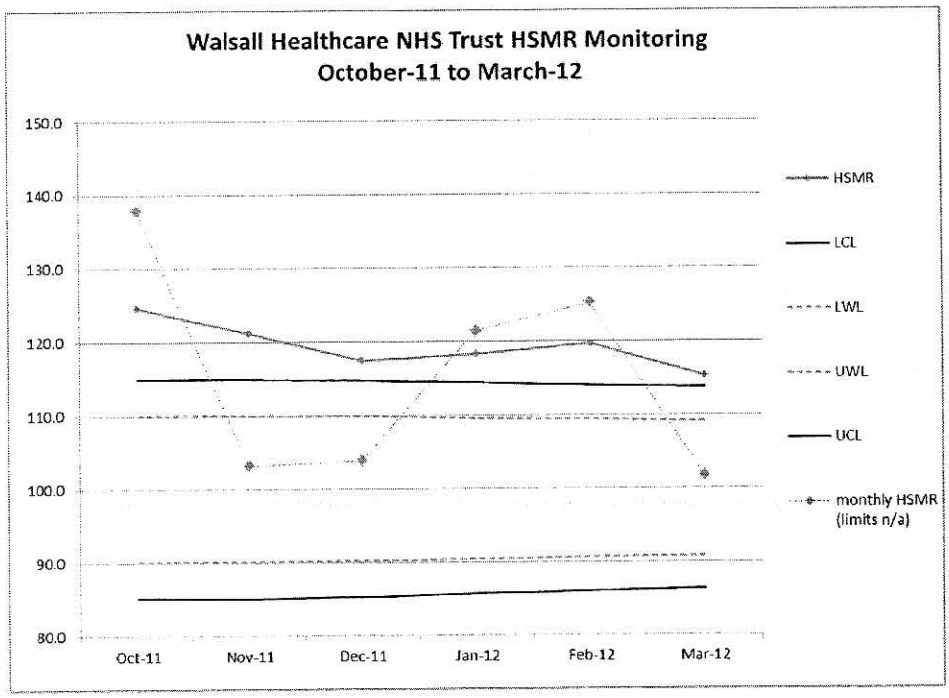
Hospital mortality ratio indicators require close scrutiny to ensure that deaths in hospital are not an indicator of poor quality or inappropriate care. Whilst there are limitations on the use of hospital mortality statistics, all efforts should be made to fully understand the underlying contributing factors and the effective activities required to ameliorate mortality rates.

Where death is unavoidable all steps should be taken to ensure patient choice in their preferred place of death is ascertained and choice facilitated by all providers in the end of life care pathway.

The SHA (East and Midlands) uses the Healthcare Evaluation Data (HED) data tool produced by University Hospitals Birmingham to monitor mortality through Hospital Standardised Mortality Ratio (HSMR) alongside mortality outlier alerts from CQC and the Summary Hospital-level Mortality Indicator.

The SHA report generated in February 2012 (six months data) showed the ratio for Walsall Healthcare Trust as higher than expected at 118. The provider Trust is implementing an updated action plan aimed at reducing the HSMR and this is being monitored by the SHA and has been reviewed by the Black Country PCTs Cluster. The latest available report (for March 2012) shows a ratio of 102.

Figure 1



Source: WM QI 2012.

This project plan details the current position within the health economy on work to understand and reduce hospital mortality ratios.

2 Context

HSMR (Hospital Standardised Mortality Ratio)

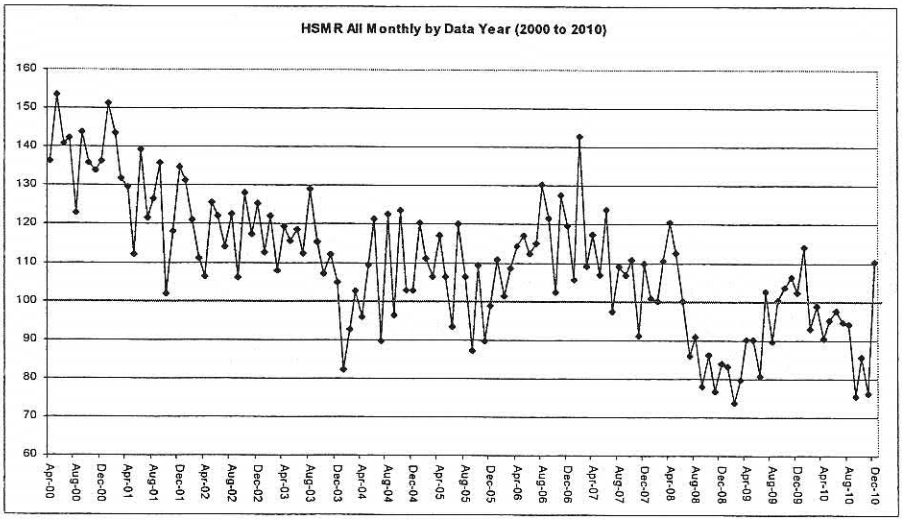
HSMR is an indicator in use for a number of years, which is a result of a complex mix of contributing factors (Appendix 1). These include:

- Case Mix (how severely ill patients are when admitted to hospital)
- Hospice availability for those at the end of life
- Quality of care provided in admitting hospital
- Lifestyle choices of patients (e.g. smoking status)
- Disease coding
- Choice in preferred place of death

There has been renewed interest in this indicator and it is now being used as part of performance template for provider hospitals (and to some extent for their host commissioning organisations).

Figure 2 HSMR in Walsall Hospital, April 2000 to December 2010

This represents the changes in HSMR for Walsall Healthcare NHS Trust (Walsall Manor Hospital) between 2000 and 2010 as calculated by Dr. Foster.



Source: Dr Foster, Imperial College London

The SHA report generated in February 2012 (six months data) showed the ratio for Walsall Healthcare Trust as higher than expected at 118. The provider Trust is implementing an updated action plan aimed at reducing the HSMR and this is being monitored by the SHA and has been reviewed by the Black Country PCTs Cluster. The latest available report (for March 2012) shows a ratio of 102.

There is a range of mortality indicators published at different frequencies (HSMR, SHMI, monthly, quarterly).

The new national indicator being introduced to monitor hospital mortality ratios – the Summary Hospital-level Mortality Indicator (SHMI) reports on a quarterly basis. Until sufficient time span has run to generate a trend, the HSMR will continue.

Data estimates

The methodology used to generate the new SHMI (Summary Hospital-level Mortality Indicator) shows how variable a hospital's position can be in the ranking depending on the indicators included in the Performance Management framework e.g. ScHaRR figures showed that for 2007-8 WHT's SHMI and rank was 1.13 (29th highest) or 1.036 (58th) depending on whether admission method and co morbidity was included or not.

Whilst that is not an excuse for poor performance (since having a high SHMI should trigger a trust and others to examine why), it does not automatically mean there is a poor standard of clinical care, and equally, poor quality care could easily be masked by a low or middle ranked SHMI.

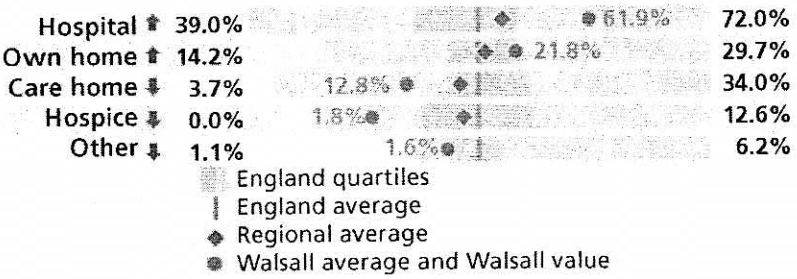
Disease Coding

Since method of admission is going to take a prominent place in the national calculations in future, it would be interesting to know how accurately this is being coded at the Manor and if there are any practices that might for instance lead to patients who might elsewhere be admitted as emergencies being coded as routine admissions. e.g. if admitted directly from outpatients, which might increase the apparent mortality (or if there is scope for gaming in the opposite direction).

Preferred place of death and hospice availability

Some 62% of Walsall deaths occur in hospital and this figure is significantly higher than the England average of 54% (Fig 3). Walsall is almost at the top of the highest quintile of local authority areas for proportion of deaths occurring in a hospital. . Until the new St Giles hospice inpatient unit opened in Goscote in April 2011 less than 2% of Walsall deaths occurred in hospices; with the opening of the new unit that has risen to over 4% of deaths (2011-12).

Figure 3.



Quality of Care

A range of standard governance processes and performance reviews have highlighted areas of both excellent and suboptimal performance. Work is underway by the SHA and the CCG to follow up improvement actions put in place.

3 Actions taken to date by the CCG

The CCG in conjunction with the Black Country PCTs Cluster has taken a number of actions in the past 12 months to both understand the rates and to assess the underlying contributing factors to local HSMRs.

The CCG has worked with the SHA to assess the quality of care provided in key specialties and departments at the hospital. For example, the appreciative enquiry visit undertaken in March 2012. Work has also been done to explore the underlying factors contributing to the HSMR, to work collaboratively with other medical directors across the region to improve the quality of clinical care and to improve the standard of care in our Nursing Homes, with specific training provided in the assessment and management of specific conditions in their residents.

The CCG is now in a position to put this intelligence into a more cohesive action plan for tracking, reviewing and reducing HSMR in Walsall.

4 Recommendation

That the Walsall CCG Governing Board agrees the following:

To establish a Mortality Clinical Reference Group to lead the 'reducing hospital mortality rates project'. This group to be chaired by a Non-Executive Director of the Black Country PCTs Cluster Board.

- To agree the project brief outlined below
- To agree the project plan for reducing hospital mortality rates

5 Project brief

Key workstreams within this project will look at the following:

a. Assurance - formal critique and performance management of the WHT action plan for reducing HSMR
b. Review and monitor the quality of care provided by WHT
c. Options for improving the care of patients in nursing homes (include quality of care and referral options for deteriorating patients)
d. Review of data, estimations of mortality rates, coding and reporting of figures
e. Addressing and strengthening the role of General Practices
f. Review of local end of life services – performance of hospices and community end of life services

5.1 Project scope

This project will develop a CCG perspective on hospital mortality rates for Walsall Healthcare Trust and the underlying contributing factors. It will draft and implement a timed plan of action for the CCG to address local HSMRs and report progress on this to key committees and bodies (e.g. OSC, SHA).

To address any relevant service issues across the Walsall health economy in any services or systems which can reduce the hospital mortality ratios.

To monitor WHT performance on existing high level indicators.

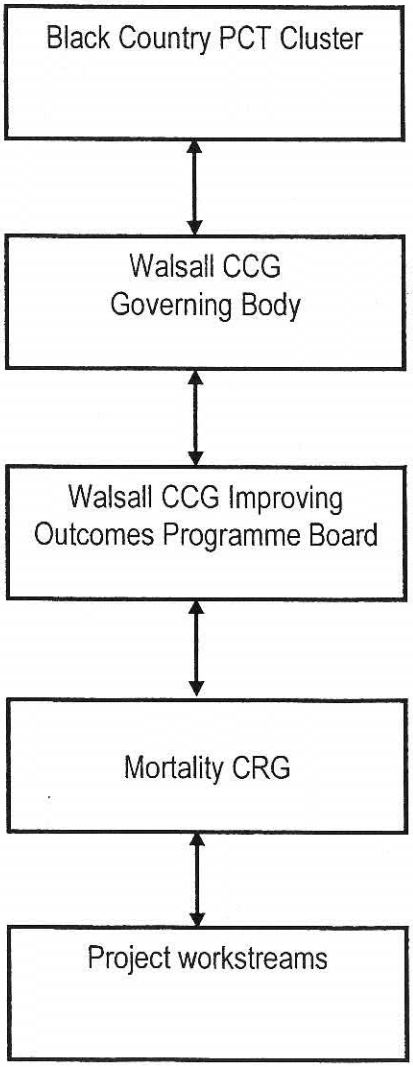
To scrutinise and challenge WHT action plans to understand the underlying preventable causes of deaths in hospital, actions to addresses these and indicators to monitor change.

To utilise independent reviewers, where necessary to critique and advise on areas for improvement and effective interventions for improving quality of care for the local health economy.

5.2 *Key stakeholders and stakeholder engagement*

Key stakeholders	Engagement	Role	Communications
CCG Board	Formal Board meetings	Act as Project Board Monitor progress of Project receive project outputs from Clinical Reference Group Direct further actions Report Project progress and outcomes to SHA and OSC	With CCG Locality Groups
SHA Cluster	Quarterly performance management reviews	Trust and CCG performance monitoring and management	Boards of respective Trust and CCG
WHT Execs	Clinical Quality Review and Contract Review Meetings	To understand determinants of HSMR and take actions to reduce, monitor and review. Engage with partners in the health economy (statutory and other sectors).	Provider clinicians and managers. Trust Board.
WHT MD and clinical leads	CQR	Design and monitor impact of clinical pathway, data collation and reporting.	Trust clinicians and partner officers relevant to pathways.
Social care and Inclusion	CCG Clinical Reference Group Care Homes Board	Collate relevant data to better understand community and care home issues contributing to HSMR. Participate in pathway redesign and commissioning Monitor and review quality of residential and nursing home care.	Walsall Council Health OSC
Black Country Quality Board		Receive project outputs. Provide Assurance to BC PCTs Cluster.	With CCGs across the Black Country
Public engagement	Communication and engagement plan to be developed	To provide insight and guidance in the understanding of the role of HSMR in the overall assessment of quality. To describe key actions which can be taken by relevant others (individuals, care sector etc) which can impact on HSMR	To be agreed.

5.3 Project lines of accountability, communication and reporting



5.4 Mortality Clinical Reference Group Membership and Workstreams

Co-ordination Roles	Lead	Working with	Comms links
CRG chair	Mr G Archenhold		BC Cluster Board
Clinical Lead	Dr Raj Mohan	GPs, independent reviewers	
Public Health mortality lead	Dr Paulette Myers	WMQI, Observatories	Health economies across WM and wider.
CCG lead nurse	Sally Roberts	SCI lead	Care Board
	Tba		
Social Care and Inclusion lead	Mr Paul Davies		Walsall Council
SHA	Trish Curran/ other		SHA performance managers
Primary Care Lead Director	Dr Narinder Sahota	GPs, Community teams	GPs
Black Country PCT Cluster Medical Director	Dr Steve Cartwright		Cluster Board

Workstreams
Assurance - formal critique and performance management of the WHT action plan for reducing HSMR
Review and monitor the quality of care provided by WHT
Options for improving the care of patients in nursing homes (include quality of care and referral options for deteriorating patients)
Review of data, estimations of mortality rates, coding and reporting of figures
Addressing and strengthening the role of General Practices
Review of local end of life services – performance of hospices and community end of life services

5.5 *Project milestones and outputs*

Objective	Outputs	Lead	Deadline
Establishing Project and Workstreams			
To establish Hospital Mortality Ratio Clinical Reference Group (CRG)	CCG Board to agree establishment and Terms of reference of project group.	IG	24.6.12
To review TOR, accountability and effectiveness of groups in LHE undertaking related work re mortality, EOL care and quality of care in residential and nursing home care and to make recommendations	Relevant groups identified and TOR confirmed in respect of mortality project.	NS	18.7.12
Undertake joint review of data sources and analysis (local, regional and national) to understand, monitor and reduce hospital mortality ratios.	Links made and key reports obtained.	PM	13.7.12
Establish reporting processes and frequency to relevant local and regional for a.	Forward project plan to Scrutiny Chair	SA	16.7.12
Assurance - formal critique and performance management of the WHT action plan for reducing HSMR Critique existing mortality reduction action plan from WHT and make recommendations as necessary	Summary critique report to project team	RM	14.7.12
Supplement current hospital mortality review group with General Practitioners + other relevant	Reviews of care provided to patients in hospital compared with published best practice.	RM	13.7.12
Review and monitor the quality of care provided by WHT Follow up recommendations from SHA/CCG Appreciative Enquiry visit - March 2012 Audit and review of key clinical pathways e.g. COPD, CHF	 Review progress Design and implement audit	 RM SC	 30.7.12 1.8.12

	(prospective)		
Options for improving the care of patients in nursing homes (include quality of care and referral options for deteriorating patients) Review end-of-life care in residential and nursing homes and make recommendations for improving.		SR/PD Independent Reviewers	
To design and implement a prospective audit of referrals for admission against agreed criteria	Process for audit and flags completed and implemented	PM	1.8.12
Review of data, estimations of mortality rates, coding and reporting of figures Strengthen links with SHA and WMQI to monitor trends in data.	Work with SHA and WMQI to review analysis of reported data.	PM	30.7.12
Critique processes for implementing coding practice in WHT	Review and compare processes with other providers	PM	30 9.12
Addressing and strengthening the role of General Practices Scope the role of primary care in end of life pathways	Detail the role of primary care in end of life pathways	NS	31.10.12
Scope the role of primary care in supporting nursing homes	Design local guideline	NS/SR	31.10.12
Identify role of primary care in key clinical pathways	Design/update local guideline	SC/NS	7.11.12
Identify the role of primary care in assessment of quality of care in hospital	Scope processes	SC	7.11.12

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Review of local end of life services – performance of hospices and community end of life services Analyse data on referrals and admissions for patients dying within 24 or 48 hours of admission to hospital	Relevant subgroup to report on common reasons for referral which may have alternate options	SR/PM	30.9.12
Review performance of hospices and community end of life services and options for improvement (particularly improving access and widening range of clinical conditions accepted)	Update service specification	SR/WG	30.9.12
Responding to interim findings or urgent issues Robust process to be put in place for communicating and actioning key findings, as necessary.	Mortality CRG and subgroups to ensure escalation of key findings or urgent issues to CCG Board.	SA	
Ensure clinical quality issues (hospital, community or independent provider) are included in local quality plans	Assure quality of nursing care across the health economy	SA	30.11.12
Future Monitoring of Agreed actions for all partners			
Agree new service specifications with WHT and care sector as required including KPIs and performance monitoring and management framework	Commissioners, individually or jointly.	SA/PD	

Version	Date	Agreed	Changes from previous
V1	28 June 2012	CCG Board	
V1.2	5 July 2012	SA/PM	Brief extended to take account of comments from partner organisations
V 1.3	10 July	Senior Management Team + Project Team	Action plan detailed, stakeholder list and roles updated. Background to project expanded.
V 1.4	11 July	SA/PM	Scope reaffirmed.
V 1.5	13 July	PM/SR	Comments from CRG added, Mortality Chair confirmed.

APPENDIX 1 – CONTRIBUTING FACTORS TO HOSPITAL MORTALITY RATIOS