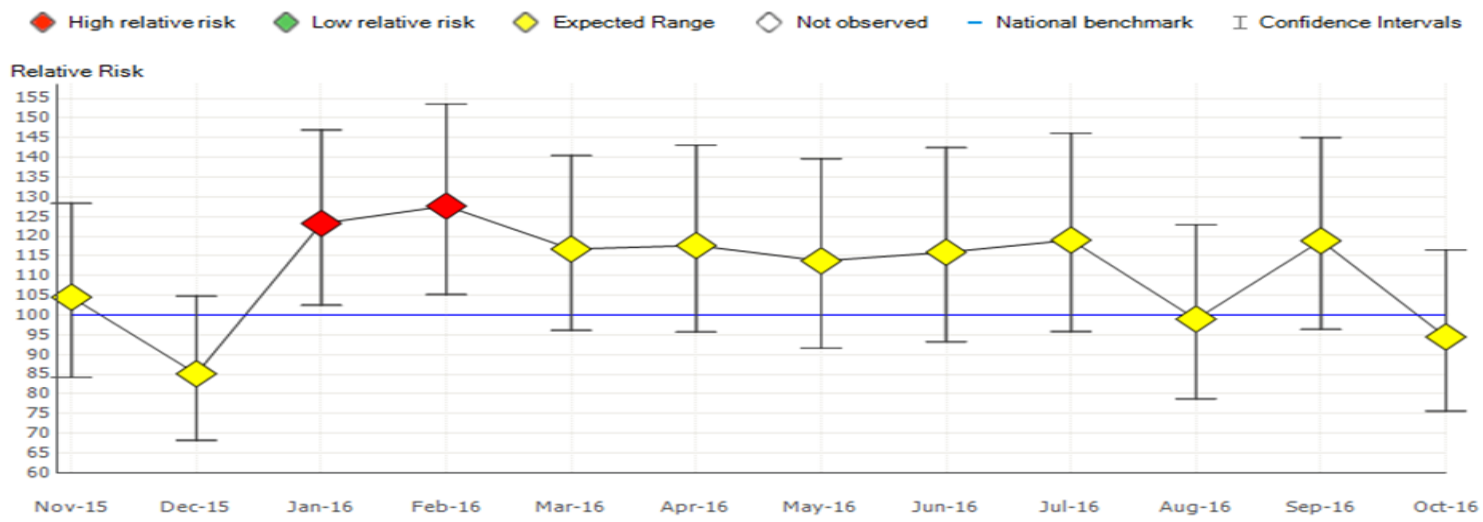
HSMR

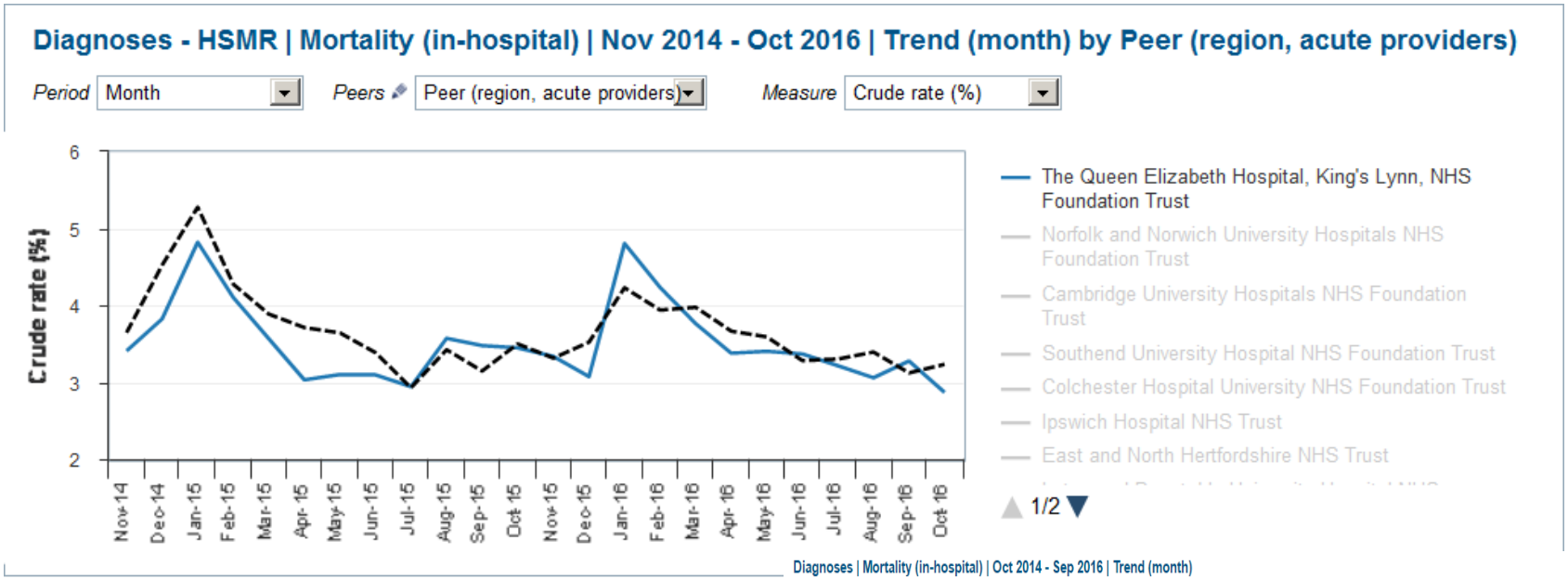
Last 12 months



HSMR 110.63 Higher than expected October 2015 to September 2016
We currently still believe this is linked to our Palliative Care coding and are working with Dr Foster to better understand this. Of note also is that our relative risk scores have changed and our expected rate has reduced from last year.
We are assured that the changes to HSMR has been influenced by data changes as our Crude and our SHMI (slightly different period) has remained stable.

Crude (Nov14-Oct16)

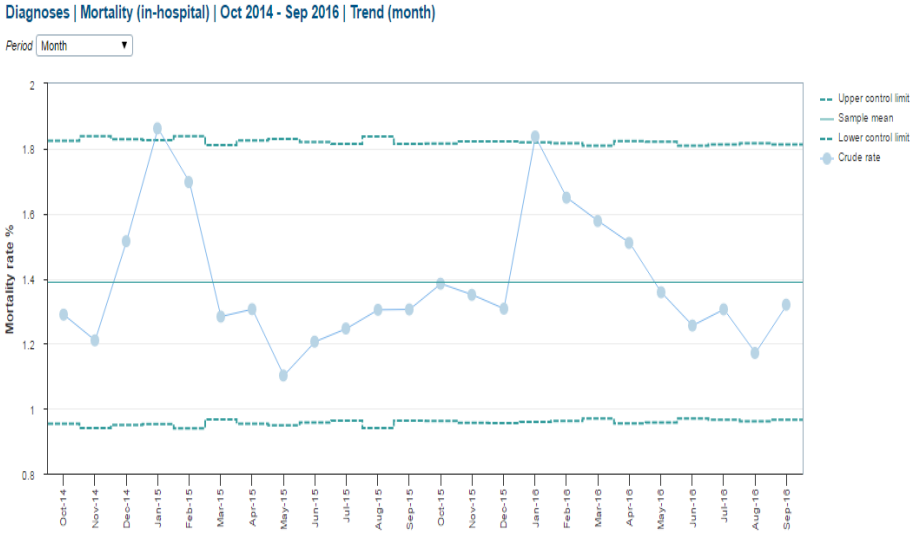
Last 24 months



Crude rate, although slightly higher than last year remains within the same profile as our peers within the Eastern region.

Crude rate with HSMR basket = 3.53% (East of England Peer group rate=3.62%)

Jan peak taken longer to recover this Year.

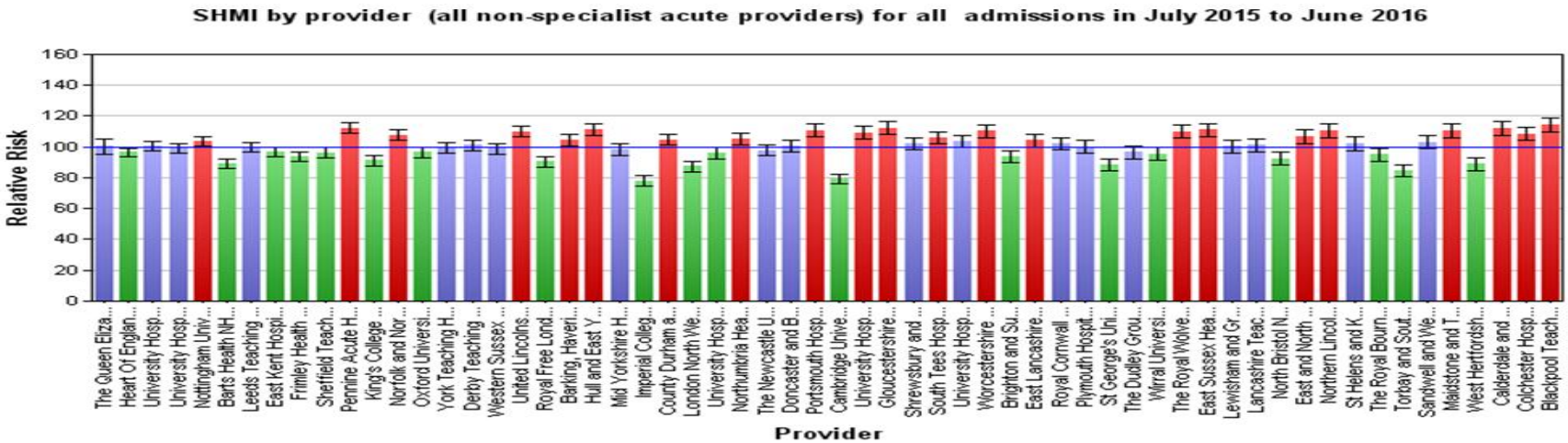


Relative Risk – Actual versus Expected

We are working with Dr Foster to better understand the influences of our relative risk. Although we recognize our deaths have increased from last year our expected rate appears to have declined. One of the key drivers is a robust diagnosis captured within the first FCE in a patients spell – the Coding Team are undertaking audits of primary diagnosis and validating with clinicians where appropriate.

	Observed	Expected
Apr-15	86	95.65272
Apr-16	100	84.99444
May-15	71	81.61797
May-16	91	79.99866
Jun-15	81	89.09236
Jun-16	90	77.62278
Jul-15	86	86.00044
Jul-16	91	76.44936

SHMI

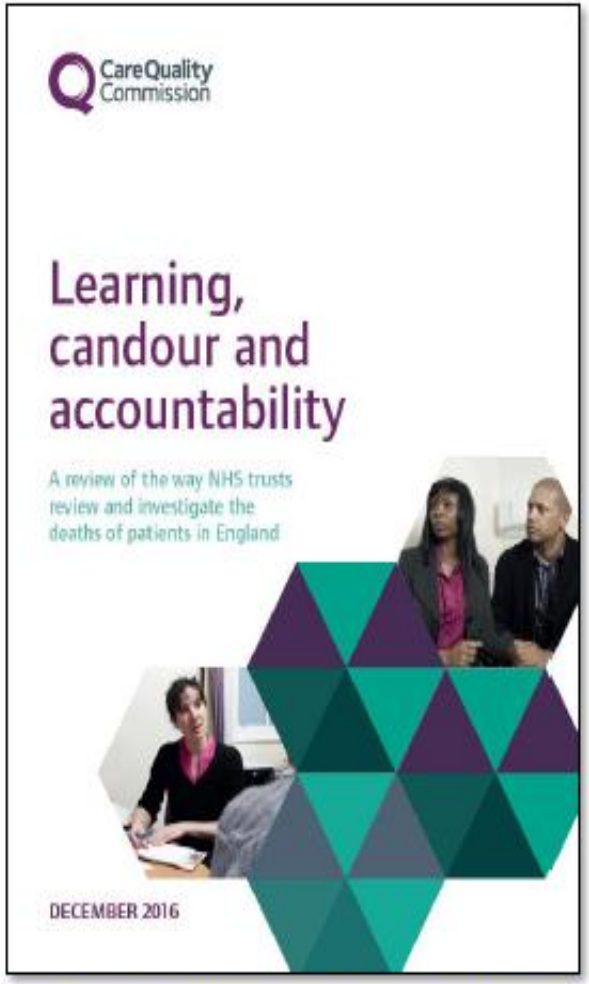


SHMI - Published (With Over Dispersion): (Jul 15 - Jun 16)

	Provider	Denominato	Obs	Exp	Obs-Exp	SHMI	Low	High
RDD	Basildon And Thurrock University Hospitals NHS Foundatior	54,390	2,036	2,054	-18	99.14	89.32	111.96
RGT	Cambridge University Hospitals NHS Foundation Trust	81,197	2,150	2,714	-564	79.22	89.50	111.73
RDE	Colchester Hospital University NHS Foundation Trust	57,572	2,247	2,070	177	108.53	89.33	111.95
RQQ	Hinchingbrooke Health Care NHS Trust	23,902	814	773	41	105.27	88.17	113.42
RGQ	Ipswich Hospital NHS Trust	54,430	1,899	1,925	-26	98.63	89.27	112.02
RGP	James Paget University Hospitals NHS Foundation Trust	30,253	1,500	1,328	172	**112.92**	88.93	112.45
RQ8	Mid Essex Hospital Services NHS Trust	54,174	1,810	1,739	71	104.08	89.19	112.12
RM1	Norfolk And Norwich University Hospitals NHS Foundation T	91,702	3,518	3,272	246	107.52	89.60	111.61
RGN	Peterborough And Stamford Hospitals NHS Foundation Trus	53,221	1,922	1,784	138	107.72	89.21	112.09
RAJ	Southend University Hospital NHS Foundation Trust	53,734	2,259	1,973	286	**114.48**	89.29	111.99
RQW	The Princess Alexandra Hospital NHS Trust	47,964	1,495	1,481	14	100.96	89.04	112.31
RCX	The Queen Elizabeth Hospital, King'S Lynn, NHS Foundatio	44,340	1,628	1,624	4	100.24	89.13	112.20
RGR	West Suffolk NHS Foundation Trust	36,052	1,337	1,533	-196	87.22	89.07	112.27

Our SHMI is 100.24 ‘as expected’ Band 2

New requirements from March 2017



http://www.cqc.org.uk/content/learning-candour-and-accountability

https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients

Recommendations

Recommendation 1:

We urge the Secretary of State for Health, and all within the health and social care system, to make this a national priority. We suggest that the Department of Health, supported by the National Quality Board – in partnership with families and carers, professional bodies, Royal Colleges and the third-sector – work together to review the findings and recommendations from our report and publish a full response. Action should then be taken to begin coordinating improvement work across multiple organisations.

Recommendation 2:

The Department of Health and the National Quality Board working with Royal Colleges and families should develop a new single framework on learning from death. This should define good practice in relation to identifying, reporting, investigating and learning from deaths in care and provide guidance for when an independent investigation may be appropriate. This should complement the Serious Incident Framework and clearly define roles and responsibilities.

Recommendations

Specifically the framework should:

Recommendation 3:

Define what families and carers can expect from healthcare providers when they are involved in the investigation process following a death of a family member or somebody they care for. This should be developed in partnership with families and carers.

Recommendation 4:

Provide solutions to the range of issues we set out for people with mental health conditions or a learning disability across national bodies, including the Royal Colleges. This should aim to improve consistency, definitions and practices that support the reduction of the increased risk of premature death.

Recommendation 5:

NHS Digital and NHS Improvement should assess how they can facilitate the development of reliable and timely systems, so that information about a death is available to all providers who have recently been involved in that patient's care. They should also provide guidance on a standard set of information to be collected by providers on all patients who have died.

Recommendations

Recommendation 6:

Health Education England should work with the Healthcare Safety Investigation Branch (HSIB) and providers to develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths and write good reports, with a focus on these leading to improvements in care.

Recommendation 7:

Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.

From March 31 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:

- Collect and report to NHS Improvement a range of specified information, to be published quarterly (this requirement will be confirmed in new regulations), on deaths that were potentially avoidable and serious incidents and consider what lessons need to be learned on a regular basis.
  - This will include estimates of how many deaths could have been prevented in their own organisation and an assessment of why this might vary positively or negatively from the national average, based on methodology adapted by the Royal College of Physicians from work by Professor Nick Black and Dr Helen Hogan.
- Alongside that data, trusts must publish evidence of learning and action that is happening as a consequence of that information.
- Identify a board-level leader (likely the medical director) as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation.
- Appoint a non-executive director to take oversight of progress.
- Follow a new, standardised national framework to be developed for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes.
- Government will ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers.

From March 31 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:

- The NHS National Quality Board will draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, Chief Investigator of Healthcare Safety.
  - These guidelines will be published before the end of March 2017, for implementation by all Trusts in the year starting April 2017.
- Health Education England will review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and maintaining their own mental health and resilience in extremely challenging situations.

Grading Deaths or Care

Expected v unexpected death: A death can be said to be unexpected if:
The patient died of an unexpected illness not suspected by the managing team
The diagnosis was suspected and the patient was treated but died despite not having bad prognostic features associated with that diagnosis
The diagnosis was suspected and the patient was treated, however the treatment was sub-optimal.

Avoidability Scale	Descriptor
1	Definitely not avoidable
2	Slight evidence of avoidability
3	Possibly avoidable (less than 50:50)
4	Probably avoidable (more than 50:50)
5	Strong evidence of avoidability
6	Definitely avoidable

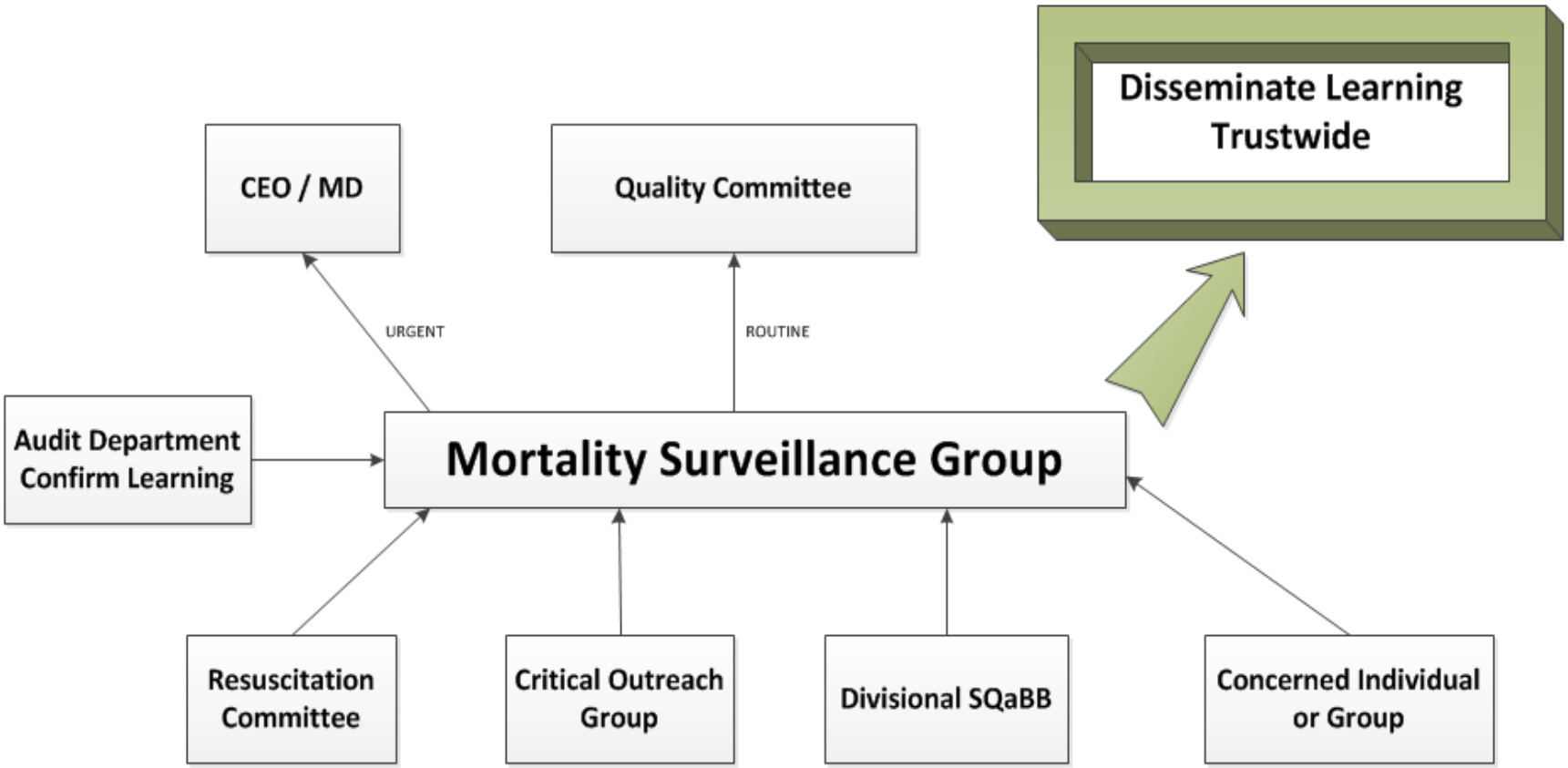
NCEPOD grade	Descriptor
1	Good practice
2	Room for improvement in clinical care
3	Room for improvement in organisational care
4	Room for improvement in clinical and organisational care
5	Less than satisfactory

PRISM Quality Scale	Considering all that you know about this patient's admission, how would you rate the OVERALL quality of healthcare received by the patient from this trust?
a	Excellent
b	Good
c	Adequate
d	Poor
e	Very poor

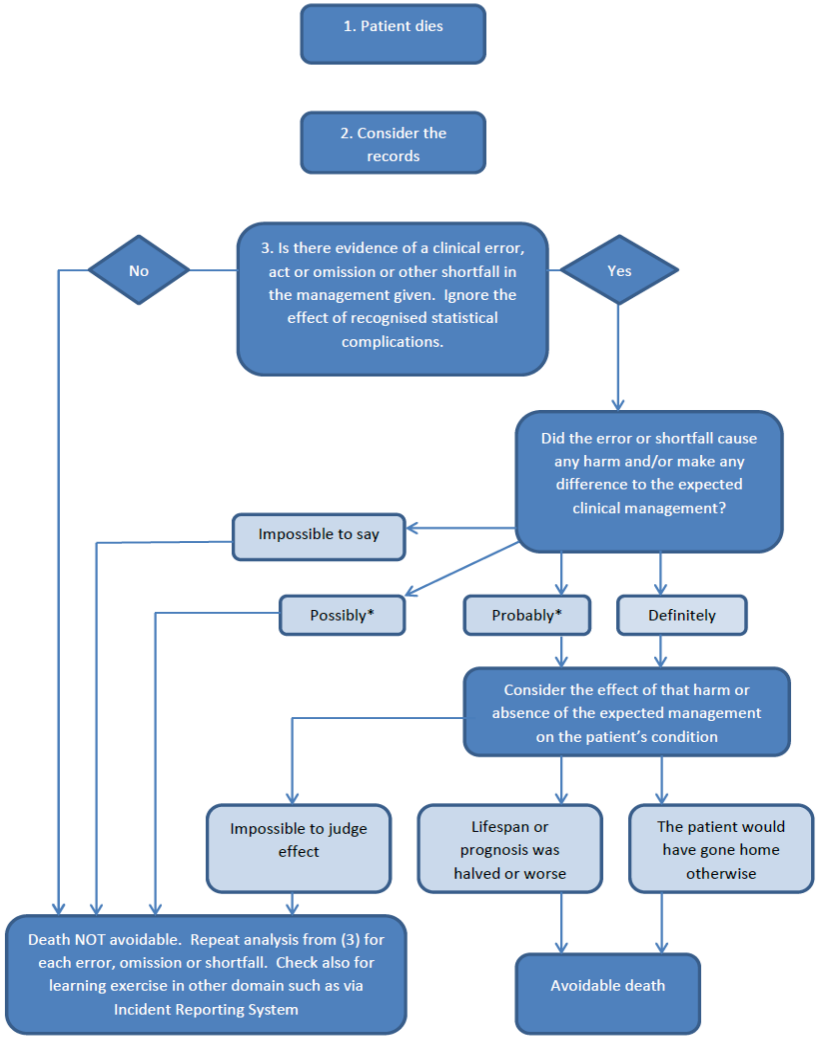
This question recognises that a problem in care can occur against a backdrop of overall good quality of care and the converse, a patient may experience poor overall quality of care without obvious harm.

For this question, do not consider healthcare prior to the admission that ended in the patient's death.

Mortality Surveillance Group Position in Trust



Decision Tree for Avoidable Death (Scores 1,2,3)



* "Possibly" and "Probably" mean less or greater than a 50% chance respectively – in accordance with the evidential rule used by the Courts

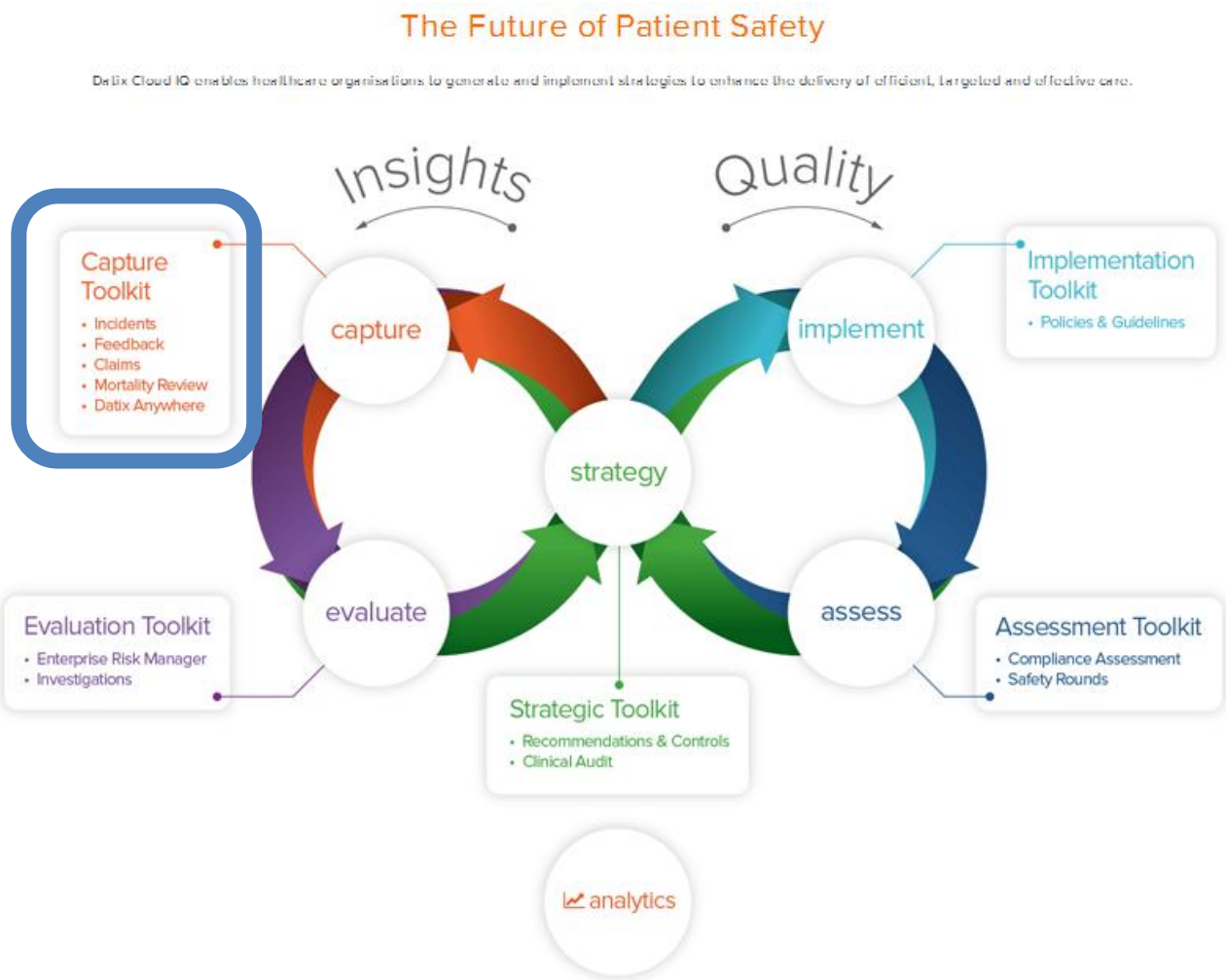
Mortality Surveillance Group

- **Issues to develop for the Mortality Surveillance Group –(MSG)**

- Percentage of deaths to be discussed given the workload
- Job planning – have SPA time as a fixed and protected session
- Source the data-most available already
- Develop specialty specific areas on the proformas for case discussion
- Develop a system for concerned individuals or groups to raise concern with the MSG
- Declare an amnesty going forward for cases not already discussed
- Develop with the audit department how they monitor changes
- Report to quality or direct to Trust board
- **Develop our systems for sharing learning across the Trust- invited experts such as military/Chemical industry**

New online Datix

Mortality reviews



- Video link for Datix IQ.
- https://vimeo.com/193692139/d5202ef815