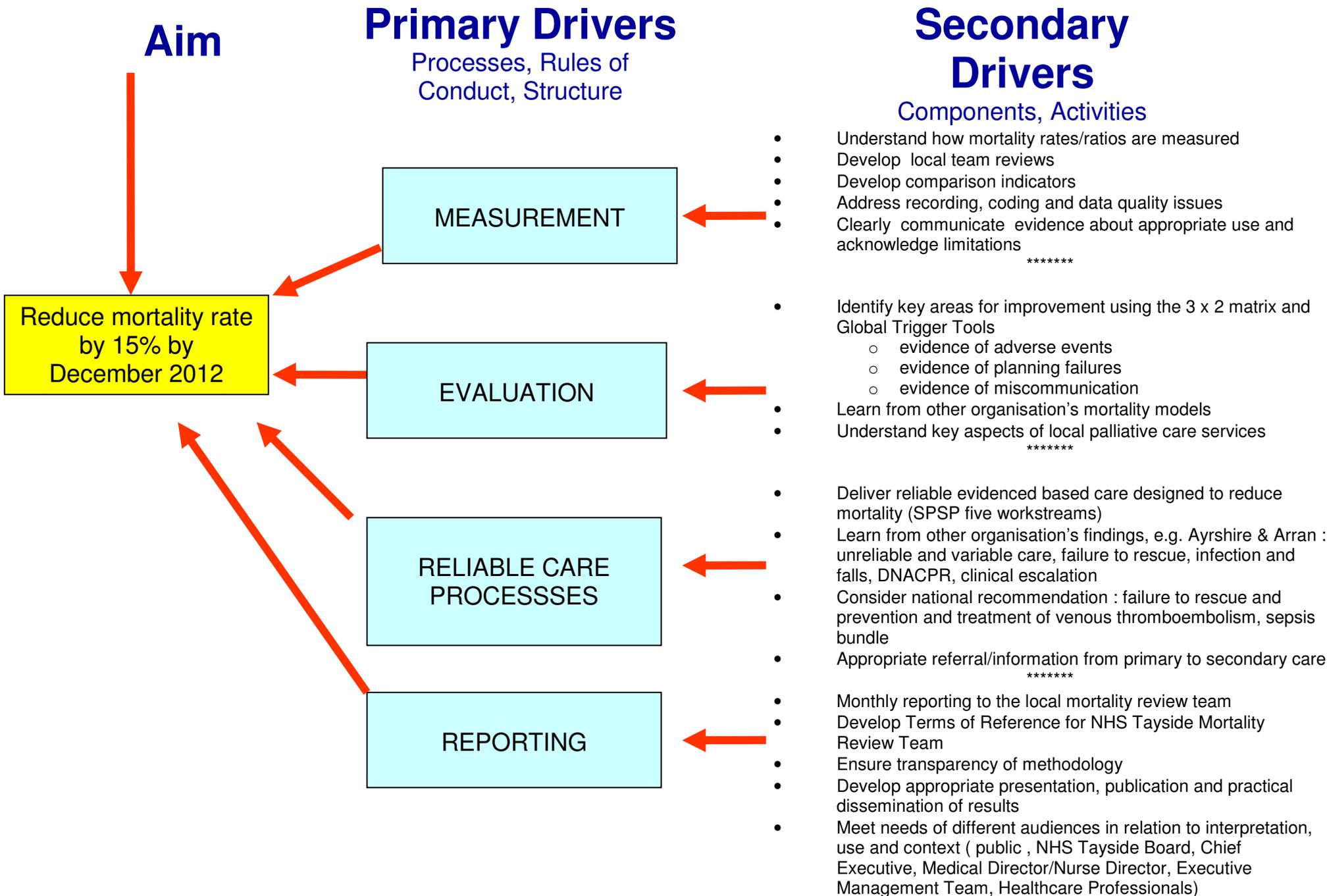


# NHS TAYSIDE MORTALITY REVIEW PROGRAMME



## NHS Tayside Mortality Review Programme

SECONDARY DRIVERS	KEY CHANGE CONCEPTS AND TEST IDEAS
<ul style="list-style-type: none"> <li>• Understand how mortality rates/ratios are measured</li> <li>• Develop local team reviews</li> <li>• Develop companion indicators</li> <li>• Address recording, coding and data quality issues</li> <li>• Clearly communicate evidence about appropriate use and acknowledge limitations</li> </ul>	<p>NB: Mortality is an important system level quality indicator, and is an essential tool for hospitals seeking to understand and reduce serious adverse outcomes of inpatient care.</p> <p>The NHS Tayside Mortality Review Group will use Hospital Standardised Mortality Rates (HSMR) and raw mortality data to help shine a light on potential areas for further analysis or investigation. This will be conducted in order to understand the underlying local context, drivers and factors affecting mortality figures. The group will :</p> <ul style="list-style-type: none"> <li>• Develop comparison indicators to prevent undue focus on one indicator in isolation. Recognise there is no 'gold standard' or single indicator which can measure good or poor quality care.</li> <li>• Use data to compliment, not replace local mortality monitoring</li> <li>• Engage with NHS Tayside clinicians to map existing local team mortality review processes.</li> <li>• Understand and address the issues relating to recording and coding of data, e.g. palliative care coding.</li> <li>• Closer engagement with ISD and CHKS in relation to coding, recording and data quantity.</li> </ul> <p>Mortality is an important system level quality indicator and is an essential tool for hospitals seeking to understand and reduce serious adverse outcomes of inpatient care.</p> <p>NB: Death rates make effective outcome measures for a number of reasons: death is a definite, unique event (unlike morbidity, which is continuous and difficult to measure consistently) Generally, HSMR closely mirrors the raw mortality rate over time, and provides a reasonable real-time proxy for the HSMR which is currently released quarterly.</p>

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SECONDARY DRIVERS	KEY CHANGE CONCEPTS AND TEST IDEAS
<ul style="list-style-type: none"> <li>• Identify key areas for improvement using the 2 x 2 matrix and Global Trigger Tools               <ul style="list-style-type: none"> <li>○ evidence of adverse events</li> <li>○ evidence of planning failures</li> <li>○ evidence of miscommunication</li> </ul> </li> <li>• Learn from other organisation's mortality models</li> <li>• Understand key aspects of local palliative care services</li> </ul>	<p>Measurement of mortality should be followed by analysis of what the rate means and what factors contribute to this and identify and implement system level changes that can reduce mortality.</p> <p>The evaluation/review process will include :</p> <ul style="list-style-type: none"> <li>• Development of a robust process to regularly review 50 consecutive patients who died within acute inpatient settings.</li> <li>• Use the Institute for Healthcare Improvement (IHI) Hospital Mortality Review Tool for this process.</li> <li>• Use the information to determine what percentage of patients who died fell into each of four categories :               <ol style="list-style-type: none"> <li>1. Patients admitted to ICU for comfort care only, suggesting overuse of ICU beds and corresponding flow issues in the ICU.</li> <li>2. Patients admitted to non-ICU beds for comfort care only may also indicate inadequate hospice or other end of life care resources in the community. Working in partnership with the CHPs is critical in exploring and addressing these issues.</li> <li>3. Patients admitted for care in the ICU represents the potential for applying evidence-based care reliably, e.g. ventilator bundle, multidisciplinary team daily goals/rounds</li> <li>4. Suggests since the outcome is death, these patients were in fact high risk and possible not rescued appropriately.</li> <li>5. Using IHI's Global Trigger Tool, perform a more comprehensive review of the charts of patients from Box 3 and 4.</li> <li>6. Identify improvement projects from the above, e.g. identifying high risk patients in admission, standardise patient handover processes, configuration of local palliative care services.</li> </ol> </li> <li>• Explore and learn from other organisation's mortality review processes that have successfully reduced mortality rates – Ayrshire &amp; Arran, Wales (confirm trust)</li> </ul>

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SECONDARY DRIVERS	KEY CHANGE CONCEPTS AND TEST IDEAS
<ul style="list-style-type: none"> <li>• Deliver reliable evidenced based care designed to reduce mortality (SPSP five workstreams)</li> <li>• Learn from other organisation's findings, e.g. Ayrshire &amp; Arran : unreliable and variable care, failure to rescue, infection and falls, DNACPR, clinical escalation</li> <li>• Consider national recommendation : failure to rescue and prevention and treatment of venous thromboembolism, sepsis bundle</li> </ul>	<p>The evaluation of data will inform and refine existing pilot testing and implementation of evidence-based SPSP interventions designed to reduce mortality.</p> <ul style="list-style-type: none"> <li>• Reduce healthcare associated infection</li> <li>• Reduce adverse surgical incidents</li> <li>• Reduce adverse drug events</li> <li>• Improve critical care outcomes</li> <li>• Improve organisational and leadership culture on safety</li> </ul> <p>In addition, NHS Tayside will learn from other organisations including recent findings by NHS Ayrshire &amp; Arran :</p> <ul style="list-style-type: none"> <li>• Unreliable and variable care</li> <li>• Failure to rescue</li> <li>• Infection and falls</li> <li>• DNA CPR</li> <li>• Clinical escalation</li> </ul> <p>ICU and HDU success stories locally and nationally</p> <ul style="list-style-type: none"> <li>• Glasgow and Clyde ICU Mortality Reduction, ALOS reduction, potential savings in waste, variation and harm.</li> </ul>

## NHS Tayside Mortality Review Programme

SECONDARY DRIVERS	KEY CHANGE CONCEPTS AND TEST IDEAS
<ul style="list-style-type: none"> <li>• Monthly reporting to the local mortality review team</li> <li>• Develop Terms of Reference for NHS Tayside Mortality Review Team</li> <li>• Ensure transparency of methodology</li> <li>• Develop appropriate presentation, publication and practical dissemination of results</li> <li>• Meet needs of different audiences in relation to interpretation, use and context ( public , NHS Tayside Board, Chief Executive, Medical Director/Nurse Director, Executive Management Team, Healthcare Professionals)</li> </ul>	<p>Recent drivers in improving patient safety and quality have led to references to mortality figures which have not always been accurate.</p> <p>NHS Tayside aims to have the monitoring and reporting of mortality established as good practice. It is important therefore to establish clear communications and guidance about the appropriate use of this data and its limitations clearly acknowledged.</p> <p>Potential reporting of this data to different groups will require :</p> <ul style="list-style-type: none"> <li>• Engage with the PFPI team to ensure relevant information is provided to patients and public to give assurance that NHS Tayside is using information to understand it's systems and make changes to improve the quality of care it delivers. Reduce the inappropriate decisions made based on mortality such as the complexity of interpreting the data, coding etc.</li> <li>• Develop a system for boards to monitor their mortality rates and actively seek to understand variances.</li> <li>• Ensuring that NHS Tayside Board looks at this as part of a dashboard of more detailed indicators.</li> <li>• Use by the Medical and Nurse Director as a potential highlighter of underlying problems which require further investigation.</li> <li>• To ensure frontline staff are aware and understand the mortality figures/trends/findings as part of the clinical governance arrangements.</li> </ul> <p>Develop Terms of Reference for the NHS Tayside Mortality Review Group.</p>