**REPORT TO CCG PARTNERSHIP BOARD. November 2015.**

**The mortality agenda and SHMI.**

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**1.0 Introduction.** As a CCG we strive to commission the best quality of care in order to achieve the best outcomes for our patients, and we therefore require ways in which we can measure the quality of services being delivered. Since the Francis Report (DH 2013) into the failing at mid-Staffordshire NHS Foundation Trust, focusing on mortality has become a standard part of assessing the performance of our hospitals and the quality of their care, and in NEL the mortality rates are high.

That said, this is not only about focusing on the quality of care in-hospital and equally includes the care of people out of hospital and within the community setting. To this end it is paramount that the CCG works closely with Northern Lincolnshire & Goole NHS Foundation Trust (NLG) as our main hospital provider, to ensure that we recognise and address the full issues in respect of mortality.

**2.0 Measuring mortality.** The Care Quality Commission (www.cqc.org) report that there are many reasons why mortality rates might be high at an organisation, and add that it doesn’t always mean there is a problem with the quality of care provided. They suggest that it could mean:

* the Trust is treating more complicated cases
* there are problems with data quality and coding, meaning that the patients who died were incorrectly assigned to a specific diagnosis.
* poor quality of care.

Measuring mortality can be done in a number of ways, the most common of which involves calculating standardised mortality ratios (SMR’s). Experts warn that hospital mortality rates can be useful indicators of quality of care, but add that careful statistical analysis is required to avoid attributing variation in mortality to differences in health care, when it is actually due to differences in case mix. Therefore any SMR measures need to be analysed and set into the context of healthcare rather than being taken purely as indicators of poor quality. It is suggested that SMR’s should be viewed as “smoke alarms” that may or may not be an indicator of something serious, but should not be ignored. It is suggested that regular examination and better understanding of hospital mortality can potentially improve the way care is delivered, recorded and coded, and in turn, help improve the quality of the data used.

The Summary Hospital-level Mortality Indicator (SHMI) is one SMR used most commonly to report on mortality at trust level across the NHS in England, using a standard and transparent methodology. It adjusts mortality rates up to 30 days after discharge for patient age, sex, type of admission, year of discharge, comorbidity, deprivation and diagnosis. The SHMI is the ratio between the actual number of patients at the Trust who die following hospitalisation, and the number that would be expected to die at the Trust on the basis of average England figures, given the characteristics of the patients treated there. SHMI is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) and compares mortality across England.

It should be clearly noted that SHMI provides a picture of when and where people are dying and is *not necessarily* reflective of inappropriate care provided by an acute hospital trust. In addition to this, we should remember the point raised above that SHMI is not only about focusing on the quality of care in-hospital and is equally about the care of people out of hospital and in the community setting, and we therefore need to be mindful to not see the SHMI data as only relevant to NLG and not to other health services locally. The SMHI data should be owned by health partners locally and work should focus on improving the quality of existing care pathways for all patients.

The demographic detail of the patients counted in SHMI needs to be further explored by the CCG Mortality Group for us to fully understand the picture and ensure we are addressing the root issues. A significant proportion of patients counted in SHMI are thought to be at end of life stage, or have a diagnosis of a long-term condition and in an advanced stage. Given this, the SHMI could be reflective of the range of options and local arrangements for end of life care, and reflective of the culture and expectations of both the public and professionals when dealing with the period around end of life. To this end the CCG and NLG must work together to achieve better experiences and options for people who are dying and their families.

**3.0 Mortality Action Plan**. The CCG have had a Mortality Action Plan in place for a period of time and a CCG Mortality Steering group to oversee its delivery. NLG also has a mortality action plan and a mortality group that meets to oversee delivery of their plan, with its membership including the Clinical Quality Lead from the CCG’s Mortality Steering Group. It would be beneficial to merge the two plans at a strategic level, whilst ensuring that the specific delivery mechanisms are in place for hospital and community care.

The CCG Mortality action plan has recently been reviewed and developed further, and will be endorsed at the next CCG Mortality Steering group & CCG Quality Committee. The newly revised action plan sets out the strategic plan of the CCG, as a commissioner, to reduce premature mortality over a 2 year period. The plan is in line with; firstly what we know from local SMR data and from findings that have emerged from work undertaken locally, for example, End to End case note reviews, and secondly, with the national guidance “Our Ambition to Reduce Premature Mortality: A resource to support commissioners in setting a level of ambition” (NHSE 2014).

The revised CCG Mortality action plan identifies priorities for year one and then subsequent work to be undertaken in year two. Further detail of the revised plan with its 9 headings can be found at Appendix 1 (page 4-5) of this report.

The CCG Mortality Steering group requires a new data set to provide assurance that the action plan is making an impact. SHMI data alone will not provide enough detail about the direction of travel for specific areas of focus, and data will be required to enable monitoring of any impact.

**4.0 Monitoring & Governance.**

The content of the revised CCG Mortality Action Plan will firstly be agreed by the CCG Mortality Steering group and Quality Committee, and will be shared with the NLG, with a view to merging it with the hospitals mortality action plan. Given the critical role the Local Authority (NELC) have to play in achieving some of the desired outcomes, it would also benefit from the endorsement of NELC & Public Health.

The following strategic groups have a key role to play in delivery of the action plan;

1. The CCG Mortality Steering Group will drive and monitor the CCG action plan above over a 2 year period. The group will receive data and reports that demonstrate the direction of travel.

2. The CCG Quality Committee will receive and acknowledge progress made and support and challenge where required, providing direction where necessary. They are required to update the CCG Partnership Board.

3. The NLG Mortality Group will drive their mortality action plan, through a number of clinically-focused workstreams linked to improving mortality.

4. A new Mortality Interface Group will be established to work on areas of interface between community and hospital pathways, and will be chaired by the CCG Director of Quality & Nursing. This group will report back to existing mortality strategic groups in NLG and the CCG. This group will also need to agree how communications and wider stakeholders will be engaged and informed.

**5.0 In summary and next steps.**

SHMI data is currently “higher than expected” and we require assurance that the quality of services is high. Mortality action plans in NLG and the CCG are currently in place and being revised to address any issues and improve our position and trajectory. However going forward we will be taking the following actions:

1. The CCG Mortality Action Plan is currently awaiting agreement at the next CCG Mortality Steering group and Quality Committee.
2. The demographic detail of the patients counted in SHMI needs to be further explored by the CCG Mortality Group for us to fully understand the picture and ensure we are addressing the root issues.
3. The CCG Mortality Steering group requires a new data set to support and enable delivery of the action plan, and to provide assurance about the direction of travel for specific areas of focus.
4. A meeting is planned with NLG to propose the following:
	1. that we merge the 2 mortality action plans held by NLG and CCG and work on 1 strategic plan that recognises workstreams for acute care and community care
	2. we create a joint task group that focuses on the interface issues between acute and community services in respect of mortality pathways
	3. we agree a communications strategy for managing the release of SHMI data and our plans to address mortality, following the recent publication of SHMI data.
5. We are planning a workshop for early 2016 to be held with primary care colleagues and potentially acute hospital colleagues, to raise awareness of the required actions within the revised mortality action plan to reduce mortality. We are being supported with this by a regional lead for mortality from PHE.
6. We need to acknowledge the resource and make the commitment required that will make a difference to mortality pathways and to SHMI data. This is required by all partners from acute and community health services, and partners around the Health & Well Being Board, and in particular the local authority and Public Health teams.

**Appendix 1 – structure of the revised CCG Mortality Action Plan.**

The following areas are highlighted by NHSE (2014) to focus attention, and the CCG Mortality Action Plan will therefore be structured under these 9 headings:

**1. Prevention and health promotion.** There are persistent inequalities in life expectancy and healthy life expectancy between communities and groups in NE Lincolnshire. The plan includes an inherent focus on reducing inequalities in life expectancy, for example, interventions such as smoking cessation support and the effective detection and management of hypertension. It aims to focus on the significant areas most likely to impact negatively on health outcomes.

**2. Cardiovascular disease (CVD**). CVD is one of the largest causes of death in NEL and the gap between our most and least deprived neighbourhood wards is widening. There are estimated to be high numbers of our population at risk of developing hypertension and familial hypercholesterolaemia, and already have undiagnosed atrial fibrillation, and early detection and appropriate early treatment could affect positive health outcomes in these cases.

**3. Cancer.** Cancer outcomes in England are poor and the elderly survive less well (NHSE 2014). The main gap is present in one year survival, suggesting late stage diagnosis and so there is broad consensus that the priority for reducing premature mortality from cancer is to improve the stage of diagnosis. However delivering earlier diagnosis is likely dependant on a package of measures across public health and the NHS; making an assumption that the cumulative effect of a range of measures designed to promote prevention and early diagnosis will achieve this. The plan includes those measures which are considered to be cost-effective, but are not necessarily cost saving (NHSE 2014).

**4. Liver disease**. Liver disease in England has trebled in the last 30 years and its morbidity and mortality and largely preventable but rely on early diagnosis and treatment, engaging primary care. Although deaths from cancer, vascular or respiratory disease are greater, 90% of deaths from liver disease are under 70 years old (NHSE 2014). Effective prevention strategies or treatments are for the main 3 causes of liver disease – alcohol, viral hepatitis and obesity.

**5. Respiratory disease**. Chronic Obstructive Airways Disease (COPD) is the 5th biggest killer disease in the UK and premature mortality from COPD in the UK was almost twice as high as the European average in 2008, and with premature mortality from Asthma being over 1.5 times higher. Although deaths from Asthma have plateaued since 2000, it is estimated that 90% are associated with preventable factors and almost 40% are under 75 years of age. Asthma is also responsible for large numbers of hospital admissions, many of which are emergency admissions. It is estimated that 2 million people have undiagnosed and untreated COPD and are likely to have had significant symptoms.

**6. Reducing mortality for people with serious mental illness (SMI)**. The focus in our mortality plan is on 2 groups of patients with SMI: firstly those with a serious mental illness i.e. schizophrenia, bipolar disorder and schizoaffective disorder (NHSE 2014), and secondly those with more common conditions including depression and personality disorder. There are real inequalities for people with SMI, with an excess of over 40,000 deaths among SMI patients which could be reduced if they received/accessed the same healthcare interventions as the general population. Mortality amongst mental health service users aged over 19 years in England was 3.6 times the rate of the general population in 2010/11 (NHSE 2014) with causes as follows: approximately four times the general population rate of deaths from respiratory and digestive system conditions, and 2.5 times the rate from circulatory conditions. Specific conditions include: liver and ischaemic heart diseases. This is thought to be because the burden of the physical condition is considered to be higher in a patient with SMI, and additionally, the risk factors are not being managed as well as in the general population.

**7. Maternal and neonatal paediatric interventions.** Whilst the infant mortality rate in NEL is low compared to the England this does not mean that we don’t have poor outcomes from the factors that affect infant mortality in NEL, for example breastfeeding, maternal obesity, maternal mental health and smoking in pregnancy. Pregnant women who smoke are more likely to cause impaired foetal growth, low birth weight, miscarriage and stillbirth, and those who are obese also risk early miscarriage, developing gestational diabetes, pre-eclampsia, experiencing thromboembolism during pregnancy and then complications during labour.

**8. Reducing premature mortality in people with learning disability.** A number of national enquiries have identified cases that illustrate where annual health checking for people with a learning disability would have made a difference to health inequality, and in some cases premature death. National guidance for commissioners provides a comprehensive guide that seeks to improve services for people with LD and should guide local commissioning (RCP, RCGP, LDO 2012)

**9. Other**. The “other” category includes; other interventions considered by NHSE (2014) to make significant impact on reducing premature mortality but do not sit within a discrete pathway of care. “Other” also includes issues, systems and process identified within NEL that are considered to contribute to premature mortality and may be areas identified through other local action planning. For example:

* Reducing mortality from sepsis
* Reducing mortality from community-acquired pneumonia
* Quality standards for the prevention of venous thromboembolism (VTE)
* Improving End of Life practice in primary care
* Learning from mortality cases
* Improve communication between primary and secondary care.

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