

## Trust Board Report

<b>Meeting Date:</b>	June 2011
<b>Title:</b>	Monthly Quality and Safety Dashboard – draft indicators
<b>Executive Summary:</b>	The report contains the proposed high level indicators for each directorate in order to provide Board members with an overview of general performance of departments.
<b>Action Requested:</b>	That the Board review the report and agree/amend the set of indicators.
<b>Report of:</b>	Director of Nursing and Midwifery
<b>Author: Contact Details:</b>	Tel: 01902 307999 ext 5959 email: c.etches@nhs.net
<b>Resource Implications:</b>	None
<b>Public or Private: (with reasons if private)</b>	Public session
<b>References: (e.g. from/to other committees)</b>	This composite of indicators will not be reviewed in this format at any other committee.
<b>Appendices/ References/ Background Reading</b>	
<b>NHS Constitution: (How it impacts on any decision-making)</b>	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> <li>✚ Equality of treatment and access to services</li> <li>✚ High standards of excellence and professionalism</li> <li>✚ Service user preferences</li> <li>✚ Cross community working</li> <li>✚ Best Value</li> <li>✚ Accountability through local influence and scrutiny</li> </ul>

## Detail

The aim of this dashboard is provide the Board members with some level of detail knowledge about directorate performance against a set of agreed indicators which may reflect the quality and safety of a patient's experience here at RWHT.

The Trust has been collecting data on our patients' safety and experience for some years. It has been reported to various committees and groups in a number of formats. The Board has been receiving a regular Quality and Safety quarterly report containing a reasonable amount of indicators in an attempt to inform Board members of Trust performance. Some detail is included in this report but by design will not give any flavour as to individual directorate challenges in this area.

Once agreed the attached report will become a monthly report to the Board of directorates' performance against an agreed set of indicators.

It is proposed that exception reports will be provided on the third month when a directorate triggers a red performance in an indicator on 3 consecutive months. An exception report will be provided by the directorate through the Division to advise the Board of reasons for adverse performance and actions being taken to resolve the issues.

The mortality indicator sheet will be reported separately as this level of information is currently only available at a Trust level, but it may be possible once the HED data system is completely fully functioning.

Board members are asked to comment of the detail of the proposed indicators and agree the set of indicators for future reporting. A review of indicators should then take place after 3-4 months to ensure that the Board find them an effective source of data to inform their opinion of clinical performance.





## BOARD MORTALITY DASHBOARD – JUNE 2011

Indicator	Period	Target	Actual	RAG	TREND
<b>HSMR</b> (DrF)	<b>Apr10- Mar-11</b>	<b>100</b>	<b>105</b> [116 rebased]	○ R	↔
<b>Observed Death Rate</b> (DrF Diag-HSMR basket)	<b>Apr10- Mar-11</b>	<b>4.3%</b> [Peer Group Average]	<b>4.0</b>	○ A	↓
<b>Expected Death Rate</b> (DrF Diag-HSMR basket)	<b>Apr10- Mar-11</b>	<b>4.3%</b> [Peer Group Average]	<b>3.8%</b>	○ R	↔
<b>Number of In Hospital Deaths</b> (DrF)	<b>March 11</b>		<b>161</b> [1761 FYE ]	○ A	↔

### Top Diagnostic Groups Contributing to Patient Deaths by Volume

	Spells	Expected Deaths	Observed Deaths	Observed Death Rate %
<b>Pneumonia</b>	<b>975</b>	<b>213</b>	<b>248</b>	<b>25.7%</b>
<b>Acute cerebrovascular disease</b>	<b>756</b>	<b>144</b>	<b>170</b>	<b>23.1%</b>
<b>Congestive heart failure, nonhypertensive</b>	<b>489</b>	<b>73</b>	<b>91</b>	<b>18.6%</b>
<b>Septicemia (except in labour)</b>	<b>202</b>	<b>69</b>	<b>81</b>	<b>40.7%</b>
<b>Acute myocardial infarction</b>	<b>845</b>	<b>56</b>	<b>67</b>	<b>7.9%</b>

Cumulative Apr 10-Mar 11

#### Cusum Statistical Mortality Alerts

Last alert received March 2011 = 0

2010-11 Cumulative= 12

#### CQC Formal Alerts 2011

Diagnostic Group	Outcome
Septicaemia Feb 2011	Clear- No further investigations
Complex Elderly Respiratory Feb 2011	Response scheduled 15 June 2011

## Associated Indicators of Mortality

### Coding

Indicator	Period	Target	Actual	RAG	TREND
<b>Charlson Codes Per Spell (HED)</b>	Jan 10	Peer Group Average	<b>4.88</b>	<b>OR</b>	↓
<b>Palliative Care Deaths Per 1000 Spell (HED)</b>	Jan 10	Peer Group Average [30], Highest Peer [60]	<b>10.8</b>	<b>OA</b>	↓
<b>Expected Death Rate (Dr F)</b>	Apr10-Mar11	Peer Group Average [4.0%]	<b>3.8%</b>	<b>OR</b>	↔

### Associated Clinical Process Indicators

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring that staff are trained to undertake these procedures and understand their clinical relevance

Indicator	Jan-11	Feb-11	Mar-11	TREND
Number cardiac arrests	41	29	32	↓
% compliance observations completed	98.0	98.0	98.0	↔

## **FACTSHEET**

### Cusum Alerts

The CuSum is a statistical process control (SPC) technique .It is designed to allow detection of changes in performance reflected by persistent deviation to an acceptable and expected rate of adverse outcomes. Mortality data is standardised to allow for differences in age, gender, seasonality etc. This is then used in calculation of the CuSum control chart and converted to the scatter plot. The trigger point is set, once the trigger point has been reached we are notified, the value is reset to half a fold for the next month. This is the initial alert system used by the CQC and acts as a basis for further investigation.

### HSMR-

The HSMR is a method of comparing mortality levels in different years, and for different patient groups within the year, while taking account of differences in casemix. The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. HSMRs are based on the routinely collected administrative data often known as HES, SUS or CDS.

The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient based upon the casemix adjustments below.

#### Adjustment for case mix

Risks take into account those patient characteristics that are most strongly correlated with death and which reflect the patient's risk profile rather than the way in which the hospital has treated them. These factors are:

- Age
- Deprivation
- Sex
- Ethnicity
- Primary diagnoses grouped into CCS groups
- Method of Admission
- Month of Admission
- Source of Admission
- Whether or not palliative care (Z51.5 code)

**Measuring hospital performance is complex. HSMRs should not be used in isolation, but rather considered with as part of a group of analytics**