

Survey on NHS trust responses to mortality alerts

Information Sheet

This survey is part of an evaluation of the national surveillance system for mortality alerts (NIHR project reference 12/178/22).

Who are we?

The project is led by Imperial College London, an academic institution. We are collaborating with the Care Quality Commission, a key stakeholder in the outcomes from this work, but we are an independently funded academic research unit supported by a grant from the National Institute for Health Research.

Aims: Why complete the survey?

The aim of the survey is to evaluate the current mortality alerting system and understand the factors governing institutional responses to mortality alerts (both internal and external) within NHS organisations. We anticipate that the outputs from this work will contribute to improvements in the alerting system, along with improved guidance on organisational arrangements for responding to alerts and reducing avoidable mortality. ***Completing the survey is an opportunity to provide feedback on the current arrangements for mortality surveillance and alerting.***

Who should complete the survey?

The survey should be completed by the principal board level mortality lead within your trust, with responsibility for overseeing investigation and response to mortality alerts received by the trust. A dedicated mortality lead role may not exist, in which case it might be appropriate for a medical director to respond as board-level lead for mortality reduction/patient safety.

Will the data be confidential?

Yes. We ask for the name of your trust and your role in order to monitor our survey response rate, but this information will be discarded prior to data analysis and ***individual trusts will not be identifiable in any outputs.***

What do we mean when we refer to “external mortality alerts”?

Where we refer to “external mortality alerts” we are referring to alerts that are generated externally to the organisation and communicated to the trust by letter (from the Dr Foster Unit at Imperial College and/or the CQC Mortality Outliers programme). We are additionally interested in your response to internally-generated alerts too, through local monitoring of mortality data, but we will make it clear in the survey when we are referring to internal alerts versus external alerts.

How do I return the survey?

Please place the completed survey in the return-addressed envelope provided before posting back to us by Tuesday 31st May 2016. In case you use a different envelope, the return address is provided below.

RETURN ADDRESS:
XXXX

If you require more space to write responses, please feel free to continue on a separate sheet of paper as required.
Thank you for your time.

Section One: About you and your role

1.1 What is the name of your Acute Care Trust? _____

1.2 What is your job title? _____

1.3 How would you describe your profession? Please select one answer only.

Clinical

Nursing

Managerial/corporate

Informatics

1.4 Which of the following best describes your role in relation to mortality reduction? Please select one answer only.

Overall executive responsibility (e.g. CEO)

Institutional lead for mortality reduction

Overall clinical responsibility (e.g. MD; Associate MD)

Other (please specify) _____

Institutional lead for patient safety/clinical governance

1.5 For how long have you had this responsibility for mortality reduction? _____

Section Two: Organisational arrangements for mortality in the last twelve months or longer (as opposed to current or future plans)

2.1 Is there a dedicated trust-level lead for mortality reduction in your trust? _____

Yes No

2.2 If YES, please specify the mortality lead's job title _____

2.3 Are there specific mortality leads appointed in the following areas in your trust? Please tick all that apply.

Individual divisions

Individual clinical specialties

Individual clinical directorates

2.4 If you have answered YES to any of the above, please provide further details. _____

2.5 Does your trust have a dedicated trust-level mortality group or committee in place currently? _____

Yes No

2.6 If NO, what group or body is responsible for mortality review and responding to mortality alerts? _____

2.7 Who chairs the group referred to in questions 2.5/2.6 above? (E.g. medical director; patient safety lead; dedicated mortality lead) _____

2.8 How frequently does this group review mortality? Please select one answer only.

Weekly

Quarterly

Fortnightly

Less than quarterly

Monthly

On an ad hoc basis

2.9 How long has the mortality review group referred to in questions 2.5/2.6 above been in place? _____

2.10 What core membership does the trust-level mortality group have? Please tick all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Executive/board-level leads | <input type="checkbox"/> Clinical leads for M&M |
| <input type="checkbox"/> Centralised/trust-wide mortality lead | <input type="checkbox"/> Junior Doctors/Doctors in training |
| <input type="checkbox"/> Centralised patient safety coordinators/leads | <input type="checkbox"/> External mortality data advisors (e.g. from a company providing mortality data) |
| <input type="checkbox"/> Centralised clinical governance leads | <input type="checkbox"/> CCG lead |
| <input type="checkbox"/> Coding team representatives | <input type="checkbox"/> GPs/Broader health economy |
| <input type="checkbox"/> Dedicated mortality coding staff | <input type="checkbox"/> Lay representation/patient representatives |
| <input type="checkbox"/> Nursing directorate representation | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Divisional leads (e.g. service leads/clinical department leads/directors) | |

2.11 What remit does the group have? Please tick all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Monitoring the activities of divisional mortality review groups | <input type="checkbox"/> Developing/compiling the external response to mortality alerts |
| <input type="checkbox"/> Monitoring variations in mortality data at trust level | <input type="checkbox"/> Developing action plans to address the causes of external mortality alerts |
| <input type="checkbox"/> Monitoring variations in mortality data at directorate level (e.g. General Medicine) | <input type="checkbox"/> Checking that action plans are implemented at local level |
| <input type="checkbox"/> Monitoring variations in mortality data at clinical specialty level (e.g. Dermatology) | <input type="checkbox"/> Development and implementation of trust-wide mortality review processes |
| <input type="checkbox"/> Investigating the causes of external mortality alerts (from Dr Foster/CQC) | <input type="checkbox"/> Holding clinical specialties to account for variations in mortality |
| <input type="checkbox"/> Investigating the causes of internally-generated signals in local mortality data | |

2.12 To what level does the group currently report? Please tick all that apply.

- | | |
|---|---|
| <input type="checkbox"/> No formal reporting mechanism for mortality group in place | <input type="checkbox"/> Reports elsewhere (please specify) _____ |
| <input type="checkbox"/> Reports to trust board | |

2.13 What additional organisational arrangements are in place for mortality? E.g. specialty level working groups; M&M meetings, etc.

Section Three: Coding, data and information for mortality in the last twelve months or longer (as opposed to current or future plans)

3.1 Which review methods are employed to ensure the accuracy of coding in your trust? Please tick all that apply.

- | | |
|---|---|
| <input type="checkbox"/> External audit of coding | <input type="checkbox"/> Dedicated training for coders using clinical input |
| <input type="checkbox"/> Internal review of coding at trust level | <input type="checkbox"/> Dedicated training for clinicians using coding input |
| <input type="checkbox"/> Specialist coders used for mortality | <input type="checkbox"/> Automatic electronic coding of comorbidities |
| <input type="checkbox"/> Consultant/clinical review of every death to confirm admission diagnosis | <input type="checkbox"/> Specific form completed by consultants for every death |
| <input type="checkbox"/> Consultant/clinical review of every death to check coding | <input type="checkbox"/> Other (please specify) _____ |

3.2 What sources/types of mortality data does your trust routinely use to monitor variations in mortality? Please tick all that apply.

- | | |
|-------------------------------|--|
| <input type="checkbox"/> HSMR | <input type="checkbox"/> Crude unadjusted data (e.g. local PAS/HES) |
| <input type="checkbox"/> SHMI | <input type="checkbox"/> Other form of risk-adjusted mortality data (please specify) _____ |
| <input type="checkbox"/> RAMI | |

3.3 If you subscribe to a data provider/analytic service which includes mortality data, please indicate which one(s) below. Please tick all that apply.

- | | |
|--|---|
| <input type="checkbox"/> CHKS | <input type="checkbox"/> CRAB |
| <input type="checkbox"/> Dr Foster Toolset | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> HED | |

3.4 At specialty level, how long in weeks is the interval between a death occurring and this being detected in your data (i.e. how many weeks lag is there in your specialty-level mortality data)? _____ weeks

3.5 Is specialty-level mortality data reviewed by the trust board as part of the organisation's key performance indicators? Yes No

Section Four: Mortality review and responding to alerts in the last twelve months or longer (as opposed to current or future plans)

4.1 How are reviews of deaths instigated within your trust? Please select one answer only.

We do not have a systematic process in place for review of deaths

Deaths are reviewed in response to both external alerts and alerts from our internal systems

Deaths are reviewed in response to an external alert only (e.g. Doctor Foster)

We routinely review all deaths, in addition to reviews instigated in response to alerts

4.2 To what extent is case note review for all deaths reliably implemented across specialties within the trust? Please provide the number of specialties and total number of specialties.

Reliably implemented in _____ out of _____ specialties within the trust

4.3 Please estimate currently what percentage of deaths are reviewed in any given period within your trust.

_____ %

4.4 Do you use a standard process or proforma for mortality review (e.g. Global trigger tool/PRISM case note review/NCEPOD classification of deaths)? If so, please name/describe it.

4.5 How are the results of case note reviews of deaths (i.e. not linked to a specific alert) formally reported within your organisation?

4.6 How are the findings of mortality reviews disseminated across the organisation?

4.7 When the trust receives an external mortality alert from Dr Foster or CQC, what action is taken initially?

4.8 When mortality review is undertaken in response to an externally-generated mortality alert, who reviews the case notes?

4.9 Are case notes reviewed by someone independent of those responsible for the care of the patient?

Yes No

4.10 Which group or role is responsible for developing actions to respond to external mortality alerts?

4.11 What mechanisms are in place to ensure that actions developed in response to external mortality alerts are implemented?

4.12 For how long have the current arrangements for mortality review been in place?

Section Five: Institutional capacity to respond to signals in mortality data

In the following items, where we refer to “signals in mortality data” we are referring to **both internally generated signals/alerts and externally-generated alerts that are sent to the trust**

Please consider the extent to which you agree with the following statements for your trust and circle the appropriate number on the scale provided.	Strongly disagree	Strongly agree
5.1 The role of the trust committee that reviews mortality is clearly defined	1 2 3 4 5 6 7 8	
5.2 Coding upon admission for all patients is accurate and appropriate	1 2 3 4 5 6 7 8	
5.3 We have sufficient capacity in informatics to analyse trends in mortality data at specialty level and generate useful signals for action	1 2 3 4 5 6 7 8	
5.4 Our local specialty-level mortality data is comprehensive, up-to-date and accurate	1 2 3 4 5 6 7 8	
5.5 We are aware when we have a potential issue with mortality in a specific area before we are alerted by an external agency	1 2 3 4 5 6 7 8	
5.6 We utilise local mortality data, patient safety and quality of care indicators effectively to understand the causes of avoidable mortality	1 2 3 4 5 6 7 8	
5.7 We investigate trends in specialty-level mortality data in a timely and efficient way that minimises risk to patients	1 2 3 4 5 6 7 8	
5.8 We have a formal and repeatable mortality review process in place at specialty level	1 2 3 4 5 6 7 8	
5.9 Our mortality review process is effective in identifying opportunities to improve quality and safety	1 2 3 4 5 6 7 8	
5.10 We have a robust process in place for making a timely response to signals detected in mortality data	1 2 3 4 5 6 7 8	
5.11 We are effective at developing specialty-specific action plans in response to signals in mortality data	1 2 3 4 5 6 7 8	
5.12 We are effective at implementing actions and making changes to reduce avoidable mortality at specialty level	1 2 3 4 5 6 7 8	
5.13 Signals from mortality data on potentially avoidable harm are communicated effectively to relevant clinical groups	1 2 3 4 5 6 7 8	
5.14 Protected time for mortality-related processes are built into people’s job roles/plans at all levels of the trust	1 2 3 4 5 6 7 8	
5.15 Senior leadership is engaged in monitoring and responding to signals in mortality data	1 2 3 4 5 6 7 8	
5.16 Senior leadership follows up on actions to reduce avoidable mortality and makes people accountable for improvement	1 2 3 4 5 6 7 8	
5.17 Reducing avoidable mortality is high on the trust agenda	1 2 3 4 5 6 7 8	
5.18 Reducing avoidable mortality was a priority in this trust prior to recent policy initiatives in the last twelve months	1 2 3 4 5 6 7 8	
5.19 All relevant professional groups collaborate effectively to reduce avoidable mortality	1 2 3 4 5 6 7 8	
5.20 There is strong clinical input to the mortality review and monitoring process at all levels	1 2 3 4 5 6 7 8	
5.21 Clinicians and coders collaborate effectively to improve the accuracy of documentation and records	1 2 3 4 5 6 7 8	

Section Six: Evaluation of mortality alerts and surveillance

In the following items, where we refer to “mortality alerts” we are referring **exclusively to externally-generated alerts sent to your trust from Dr Foster and/or the CQC.**

Please consider the extent to which you would agree with the following statements, based upon your experience of receiving and responding to alerts.	Strongly disagree	Strongly agree
6.1 The risk adjustment model and thresholds upon which externally-generated alerts are based are accurate and fit for purpose	1	2 3 4 5 6 7 8
6.2 It is important to allocate staff and resources to investigate externally-generated mortality alerts	1	2 3 4 5 6 7 8
6.3 Mortality alerts sent to a trust represent valid and reliable signals of problems in care delivery	1	2 3 4 5 6 7 8
6.4 Continued mortality alerting and surveillance focuses trust priorities on avoidable mortality in a useful way	1	2 3 4 5 6 7 8
6.5 Receiving mortality alerts leads to improved multi-professional collaboration on mortality reduction	1	2 3 4 5 6 7 8
6.6 Receiving mortality alerts leads to improvements in the accuracy of coding	1	2 3 4 5 6 7 8
6.7 Receiving mortality alerts leads to improvements in our methods for investigation and review of mortality	1	2 3 4 5 6 7 8
6.8 Receiving mortality alerts leads to improvements in local monitoring and reporting of trends in mortality data	1	2 3 4 5 6 7 8
6.9 Monitoring mortality alerts is an important component of external regulation and quality assurance	1	2 3 4 5 6 7 8
6.10 The investment of effort in responding to mortality alerts is justified by the potential benefits to patients	1	2 3 4 5 6 7 8
6.11 Having a mortality alerting process in place should increase public confidence in the safety of NHS services	1	2 3 4 5 6 7 8
6.12 Overall, mortality alerting and follow-up is an effective mechanism for reducing avoidable mortality	1	2 3 4 5 6 7 8

