Report of the Director of
Policy and Resources

Agenda Item No: 9
Meeting: 12 November, 2013

NORTH LINCOLNSHIRE COUNCIL

CABINET

THE STANDARDISED HOSPITAL MORTALITY INDEX (SHMI) IN NORTH LINCOLNSHIRE - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS OF THE HEALTH SCRUTINY PANEL

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To update cabinet on an action plan in response to the recommendations of the Health Scrutiny Panel in relation to the Standardised Hospital Mortality Index (SHMI) in North Lincolnshire and Goole.

2. BACKGROUND INFORMATION

2.1 At its meeting held on 24 September 2012 cabinet considered a report of the Health Scrutiny Panel in connection with the Standardised Hospital Mortality Index (SHMI) in Northern Lincolnshire and Goole. Cabinet agreed that an action plan in response to the recommendations should be submitted to cabinet at this meeting.

2.2 Attached as an appendix to this report is an action plan in response to the recommendations of the Health Scrutiny Panel.

3. OPTIONS FOR CONSIDERATION

3.1 Cabinet is asked to agree the action plan.

4. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

4.1 There may be some resource implications associated with the recommendations when they are implemented.

5. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

5.1 The Northern Lincolnshire and Goole Health Community will have dealt with the Impact Assessment of their work in relation to this matter.

6. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTEREST DECLARED

6.1 Consultations took place when the Health Scrutiny Panel produced its report.

7. **RECOMMENDATIONS**

7.1 That the action plan be approved and adopted.

DIRECTOR OF POLICY AND RESOURCES

Civic Centre
Ashby Road
SCUNTHORPE
North Lincolnshire
DN16 1AB
MDH/LMK
Author: Mel Holmes
Date: 1 November 2013

Background Papers used in the preparation of this report - Nil

OSC Report – The Standardised Hospital Mortality Index in Northern Lincolnshire and Goole

Joint response NLCCG and NLAGFT

Recommendation	Response
1. The panel recommends that the Northern Lincolnshire Health Community commit to commissioning Phase 2 of an external review into SHMI across Northern Lincolnshire in 2013-14. We further recommend that a key component of this review should be a wide-ranging review of staffing levels at Northern Lincolnshire & Goole Hospitals Trust (NLAG) at all times, and across all sites and specialities, and whether senior staff are on-site or on-call. The terms of reference set for this review should include discussions with primary and secondary care practitioners and clinicians.	The purpose of a stage 2 review referred to in the THL report was to undertake more detailed analysis to support action plan development and the securement of improvement. The Mortality Action Group and the CCGs view is that the Bruce Keogh Rapid Responsive Review (BKRRR) which has taken place since is sufficient at this time and has provided the necessary further analysis. The focus at the current time must be on implementing the actions identified both within the existing mortality action plan and those following the BKRRR review. A review of staffing levels is underway within NLAG and details of this will be included in the Monthly Staffing Report to the Trust Board. These reports are shared with the CCG and are public documents, which can be found on the Trust intranet.
2. The panel recommends that North Lincolnshire Clinical Commissioning Group (NLCCG) receive regular and detailed NLAG staffing reports at public meetings of their Board.	The CCG receive all quality reports that are presented to NLAG Board and these contain information regarding nurse staffing levels. The CCG have requested via the Contract Management Board significantly more information relating to the NLAG. Workforce including medical staffing. This information will be taken through the CCG Quality Group, a sub group of the CCG Governing Body. Any concerns raised will be addressed through the Contract Management Board and at

	Quality Group and CCG Governing Body via the Board Assurance Framework (BAF) if appropriate. NLAG can confirm that the Monthly Staffing Report includes both medical and nursing data and, as mentioned above, this is a public document, made available on the Trust intranet.
3. The panel recommends that staffing reports presented at NLAG□s Board of Directors and NLCCG□s Board should include peer comparison rates to enable informed comparison. We further recommend that all staffing reports should also include staffing levels that include levels of consultants, doctors, and other key personnel, and the usage of bank or „agency□ staff.	A staffing report is being received as outlined above (see recommendation 2 response). The usefulness of 'peer' comparisons will be considered by the CCG working with NLAGFT.
4. The panel recommends that every speciality at NLAG with a high (perhaps 120+, or for local determination) SHMI rate, or that is identified in the CQC Risk Profile, should automatically trigger an internal clinical review, an analysis by the Trust□s Quality and Audit Team, and if thought appropriate by NLAG□s Medical Director, a peer review. NLCCG and NELCCG should also maintain an oversight of this work.	This is already underway and reported via the Northern Lincolnshire Mortality Action Group. The Monthly Mortality Report produced by NLAG provides further detail on the work undertaken by the clinical condition specific work groups.
5. The panel recommends that the NLAG and the wider Northern Lincolnshire Health Community Mortality Action Group Action Plans be amalgamated as soon as is practical, and that all actions are drafted to comply with SMART1 principles. All actions should result in actual changes at ward, bed or	The action plan which has been provided is a combined action plan consolidating actions from the THL report, NLAG internal plan and the BKRRR agreed actions. This has been done because of the concern that the number of

community level, and not simply be about producing reports and maintaining oversight.	actions and individual action plans is distracting from the delivery of priority actions.
6. The panel further recommends that a review is undertaken of the combined action plan, in order to ensure that all of THL's original recommendations are incorporated, or if they aren't, that there is a clear and evidenced public explanation why not. We further recommend that the combined action plan include an appendix of completed actions to ensure that the public are aware of progress and completed work.	The actions following the THL report have either been • archived as delivered, • moved for delivery into the Healthy Lives Healthy Futures Review as they are longer term • or they are consolidated into the combined action plan as being deliverable in the shorter term. The Mortality Action Group which reviews progress includes public representatives.
7. The panel recommends that there be stricter oversight of progress on the combined action plan by all Chairs, NLAG's Chief Executive and the Chief Officers of the three CCGs to ensure that there is the necessary leadership to reduce the number of delayed actions and the significant number of amber targets.	The Chairs, Chief Officers and NLAG Chief Executive do discuss progress regularly and have agreed how monitoring progress will be further strengthened through the work of the Contract Monitoring Board and Quality Monitoring Group the later chaired by the CCG chair. The above are fully briefed by those Senior Staff who lead on mortality within their organisation. The Chief Officer of NEL CCG Chairs the Mortality Action Group. The CCG Governing Body, including lead GP's receive regular briefings via CCG Workshops. The SHMI is a standing item on each NLCCG Engine Room Agenda which includes Chief Officer and CCG chair as members. These minutes are received by the

	CCG Governing Body. SHMI is also a standing agenda item at the CCG Quality Group which is a formal sub-committee of the CCG Governing Body who in turn receive the minutes. The CCG Quality Group and the CCG Governing Body review the Board Assurance Framework monthly of which SHMI is a key element. Recently a Summit was held with the CCGs and NLAG, and officers of the NY&H AT of NHSE, it provided assurance on the processes for review, and monitoring delivery locally. In addition to these local processes, considerable oversight is being undertaken by Monitor. The Trust has monthly meetings with Monitor and an Independent Director has been appointed via Monitor who spends two days per week in the Trust supporting on the delivery of the Keogh action plan.
8. The panel recommends that the Northern Lincolnshire Health Community Mortality Action Group continue to meet regularly for the foreseeable future, in order to co-ordinate action and provide accountability in reducing the SHMI to „typical“ rates and beyond.	There are no plans to disband the Mortality Action Group which continues to meet monthly.
9. That, as recommended in North Lincolnshire DPH□s 2011-12 Annual Report mentioned on page X, a method of allowing advice and input from a suitably senior public health practitioner	North Lincolnshire Public Health input is provided to the work of the Mortality Action Group through the Analysts sub group. The North Lincolnshire Director of Public Health attends the NL CCG

to the work of the Northern Lincolnshire Health Community Mortality Action Group be agreed.	Governing body and the CCG ER where as outlined above SHMI and the Mortality Action plan is discussed. The CCG Chief Officer will discuss with the DPH whether she feels and further input is needed.
10. The panel is unconvinced that reducing multiple ward transfers, bed occupancy rates and excess mortality arising from weekend admission are satisfactorily addressed within the action plans. There is a clear need to identify actions at both ward and strategic level. We recommend that these three issues, that remain of concern, are strengthened within a combined action plan and are set out in much more detail with clear ownership, accountability and timescales.	The work being undertaken to address these issues is outlined clearly in the Keogh action plan which has been agreed with Monitor.
11. Following a number of concerns highlighted in the THL report regarding comparable data not being available at all NLAG sites for conditions such as cardiac arrests, the panel recommends that NLAG conduct a verification exercise to ensure that both site-specific and comparable Trust-wide data is routinely collected, monitored, and freely available.	NLAG uses peer review data wherever this is available.
12. The panel remains concerned that there is no robust system to monitor out-of-hospital deaths. The panel recommends that the Northern Lincolnshire Health Community Mortality Action Group prioritise this action to ensure that every death outside of	A project is underway to address this led by Dr Robert Jaggs-Fowler NL CCG Medical Director. This has started with a review of deaths within 30 days of discharge. Dr Jaggs-Fowler is working closing with the Chief Nurse and Acting Medical Director

hospital is reviewed by a GP.	from NLAG. Dr Jaggs-Fowler is also exploring the use of a Primary Care ‘trigger’ tool.
13. The THL report concluded that “there will be data available for community and care homes but there is no central data source to monitor this important indicator of good end of life care”. The panel recommends that the Northern Lincolnshire Health Community Mortality Action Group work with these organisations to develop and share a centralised database of relevant information.	The CCG Medical Director has had discussion and there is a willingness to progress this. However at this time national issues regarding the sharing of patient identifiable data prohibit progress. Once this is resolved national it will be progressed.
14. The panel recommends that the Northern Lincolnshire Health Community Mortality Action Group explore the reasons why the mortality rate outside of hospital is rising, as referenced on page x, taking appropriate action.	This is included in the work referred to in recommendation 12 above.
15. The panel is unsure whether NLAG have reviewed the reasons for the spike of cardiac arrests on Wednesdays. We recommend that this phenomenon is reviewed with some degree of urgency by clinicians, with appropriate support, with remedial action taken as necessary. The panel further recommends that the on going and lengthy cardiac arrest audit be prioritised by NLAG.	This issue is considered within the condition specific mortality group for cardiac conditions and the NLAG also provides data for the National Cardiac Arrest Audit.