Imperial College London

CPSSQ
Centre for Patient Safety & Service Quality

Evaluation of a National Surveillance System for Mortality Alerts

Information for NHS trust participants

1. Is the research independent of the CQC?

Yes, the research is being conducted independently from the CQC. The CQC are involved in the project as a stakeholder since they issue mortality alerts and are keen to know the outcome of the research to inform the future of their alerting system.

We will be using information about the alerting trusts that is in the public domain on the CQC website.

2. Who are the research team and what is their track record?

The project is led by Dr Paul Aylin, Clinical Reader in Epidemiology and Public Health and co-director of the Dr Foster Unit at Imperial College (DFU). He is experienced in developing indicators based on routinely collected data and led the development of Imperial College's national mortality alerting system. He is theme lead at the NIHR-funded Imperial Patient Safety Translational Research Centre (PSTRRU).

Dr Alex Bottle is Senior Lecturer in Medical Statistics, expert in HES use, and devised the alerting system methodology (risk-adjustment models and setting control chart thresholds). He will oversee data extraction and analysis and provide statistical advice.

Professor Charles Vincent is a psychologist based at Oxford University and is a world expert in patient safety. He will provide expertise and guidance for the project.

Dr Jonathan Benn is a psychologist and Lecturer in Quality Improvement at CPSSQ, experienced mixed methods research lead, including the UK Safer Patients Initiative (multi-site qualitative work and longitudinal survey study).

Susan Burnett is an experienced NHS manager having occupied roles including director of national programmes at the National Patient Safety Agency and deputy chief executive of a university teaching hospital. She was a member of the national taskforce on preventing never events and is a member of the Royal Society of Medicine's patient safety section council. She brings Health Service management expertise to the project.

Aneez Esmail is Professor of General Practice at Manchester University and Director of NIHR Greater Manchester Primary Care Patient Safety Translational Centre. He was Medical Advisor to the Shipman Inquiry and will be an independent co-investigator. He will contribute to development, management, design of the study and publication of results.

3. What is the background to the research?

Since 2007, the Dr Foster Unit at Imperial College (DFU) has generated monthly mortality alerts using routinely collected hospital administrative data for all English acute NHS hospital trusts. A mortality alert is sent to a trust at no charge (irrespective of whether the trust has a commercial relationship with Dr Foster Intelligence) and a copy is sent to the Care Quality Commission (CQC). The CQC also run a mortality alerting system. When an alert is sent out from either system, the CQC writes to the trust and asks for a response, which is then logged. This joint mortality surveillance system was pivotal in alerting the then Healthcare Commission (HCC) to problems at Mid Staffordshire NHS Foundation Trust. The resulting Public Inquiry recommended that trusts should have systems that provide real-time information on mortality, patient safety and quality of care.

We are now conducting an evaluation of the system for mortality alerts with the aim of improving our understanding of how the alerts are received and dealt with by Trusts and to find out about their impact as an intervention to reduce avoidable mortality.

The research is being funded by the National Institute for Health Research (NIHR).

4. What are the research methods?

The first part of the research is desk based where we are looking to see if there is a relationship between mortality alerts and other routine data available for trusts. In this part of the research we are also looking at the data to assess the impact of the alerts on reducing avoidable mortality. The second part of the research is looking at the actual impact of the alerts on trusts, what they do with them; how they respond; whether there are any particular local factors that affect the response; and what actions are most effective. Here we are focussing on two conditions as set out below.

5. How will the research benefit my trust and the NHS?

We will be able to provide your trust with feedback and insight into your response to mortality alerts in comparison to other participating organisations. However, the main benefit from the research will be a better understanding of the use of administrative data for monitoring mortality at a local and national level together with recommendations for improving the surveillance systems for the quality of care in the NHS as a whole. A further benefit will be the guidance we will produce for trusts on best practice in responding to alerts.

From our findings about how trusts respond to alerts we will be able to contribute to national quality improvement initiatives for the conditions being studied.

6. Why focus on Acute Myocardial Infarction (AMI) and Septicaemia?

DFU currently issues alerts covering 122 diagnoses and procedures and we have chosen to focus on two conditions in the research. The two conditions chosen are those most commonly attributed to mortality alerts - acute myocardial infarction and septicaemia – and the two that potentially require a hospital wide response.

7. What will this involve in my trust?

We want to interview the key people involved in receiving and responding to mortality alerts in the trust and in particular those involved in responding to alerts for AMI and Septicaemia. We envisage that this might be up to 12 people. The interviews will be either by phone or face to face and will last up to an hour at most. They will be anonymised so the individuals cannot be identified.

We will also want to review documentary data including minutes of relevant meetings, action plans addressing the alerts and so on.

The results from the research in the 12 trusts will feed into a national survey to find out how all trusts view and respond to mortality alerts.

8. Are there any risks in taking part? Will the trust be kept confidential?

The names of the participating trusts will be kept confidential in our research. All data and field notes will be given a code to ensure anonymity and stored in a locked filing cabinet or on a password protected computer secured against unauthorised access. We will not name the trusts in any publications or presentations arising from the research. However, it must be noted that we will be using data that is already in the public domain about which trusts have received mortality alerts for these conditions, for example on the CQC web site.

9. What happens if a researcher identifies a serious concern?

We will identify a lead person from your trust who can be contacted if someone tells us something during an interview that indicates there is a risk of harm in the trust. We will tell the interviewee that the information will be disclosed to the person identified for normal trust procedures to then be followed.

10. Has this study been reviewed by an ethics committee?

This study has been reviewed by the Imperial College Ethics Committee and since no patients are involved and we are only interviewing NHS staff, the research does not need ethics approval but will need local R&D approval at each site, which we will arrange.

11. What will happen to the results of the research study?

We will be drawing up case studies of each organisation and then conducting an analysis across the hospitals involved in the research. Each case study will be anonymised so the trusts cannot be identified. We will provide each participating trust with a report of our findings and our recommendations.

The results of the project may be used to inform future policy, be published in academic journals and/or presented at professional and academic conferences.

Anonymised extracts from the interviews may be used in publications arising from this research. Reports or papers resulting from the research will not identify any one who has taken part.

12. If we agree to participate what happens next?

Once you agree to participate we will ask you to identify a lead person that we can liaise with. We will arrange local R&D approval and once this has been received we will arrange to visit the trust and to set up interviews with the relevant people.