NHS
Newark and Sherwood
Clinical Commissioning Group

Health Scrutiny Committee

Mortality Rates Briefing

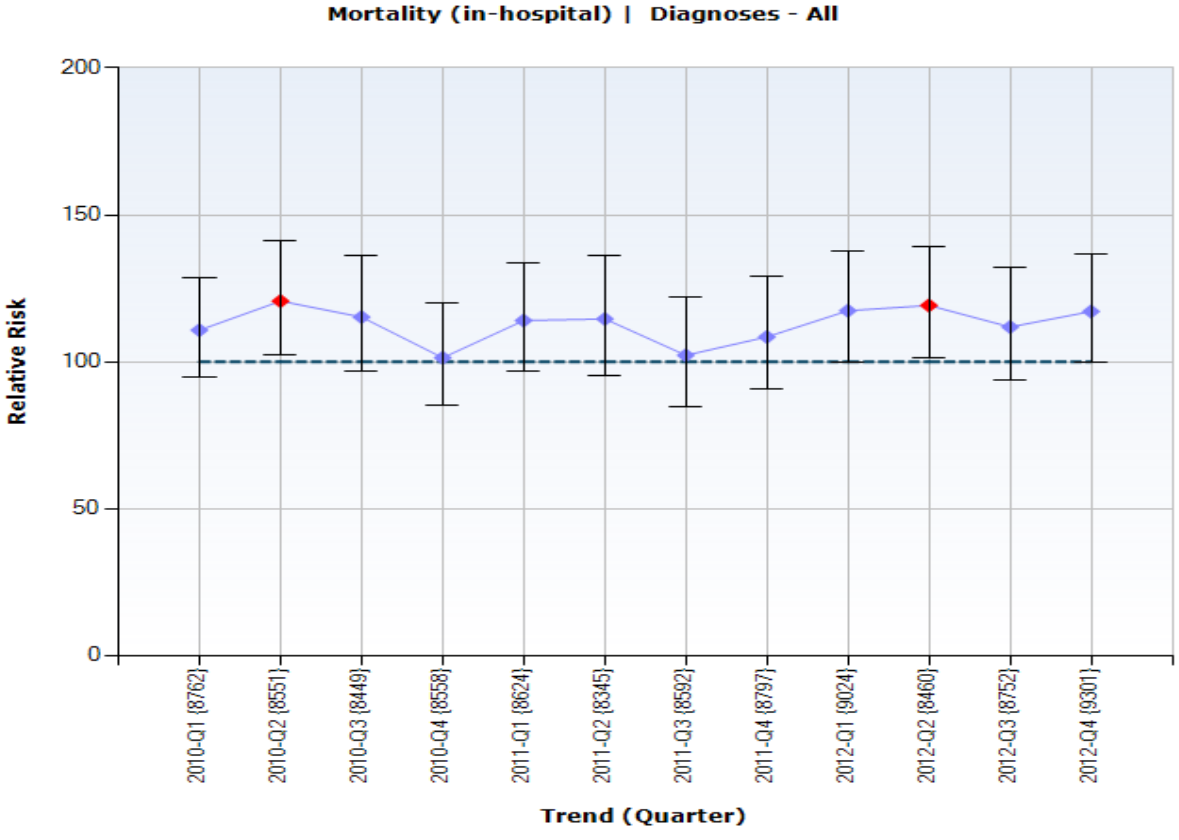
July 2013

1. Mortality rates are a cause for concern across Mid-Nottinghamshire

Unfortunately, Sherwood Forest Hospitals and United Lincolnshire Hospitals both have comparatively high hospital mortality rates (Hospital Standardised Mortality Rates, HSMRs) when compared to other hospitals across the country. A key focus for us is to improve our mortality rates to be level with the best in the country. This will be achieved by having the best clinical practice in place within our hospitals, as well as excellent primary care, community and ambulance services.

Average hospital death rates have fallen year on year across the country, but progress has been comparatively slower in some of our local hospitals. This means that the HSMR has appeared to deteriorate when compared to other hospitals around the country. The average rate is 100.

The HSMR for Newark and Sherwood CCG is shown below:



The other national measure of death rates (Summary Hospital-level Mortality Indicator, SHMI) measures all deaths within 30 days of admission, regardless of where the death occurs. This is the Department of Health approved measure and does not show such worrying trends locally. The reasons for these differing findings are not clear, but have also occurred in other hospitals.

This table shows the SHMI rates by hospital trust. SHMI data are published at provider level and are not published by postcode or CCG.

Hospital Provider	SHMI Rating (April 2010 to March 2011)	SHMI Rating (April 2011 to March 2012)	SHMI Rating (Oct 2011 to Sept 2012
Sherwood Forest Hospitals	1.030	1.028	1.079
United Lincolnshire Hospitals	1.058	1.093	1.099
Nottingham University Hospitals	0.967	0.927	0.938

14 hospitals are now subject to the national Keogh review because they have either had high HSMR or SHMI levels over the last two years. This took place in June at Sherwood Forest Hospitals and United Lincolnshire Hospitals. We worked with the review team at Sherwood Forest Hospitals and attended the public listening events. The report is due to be published soon.

The CCG is working closely with Sherwood Forest Hospitals to improve the HSMR. This will benefit all patients who are admitted to the hospital and not just people who live in Newark and Sherwood. Considerable work has been undertaken over the last 6 months to improve the position, particularly in relation to sepsis, early detection of deterioration within hospital ward environments and renal care. The stroke and heart attack pathways for patients once they arrive at the hospital have also been reviewed.

2. Newark mortality rates have been in the headlines recently, following the Sunday Mail publication of campaign group figures.

The Sunday Mail published allegations about rising mortality rates as a consequence of the change from an A&E to an MIU. The figures were from FOI requests from 6 hospitals. The way the figures were put together and the conclusions that were drawn have not been validated.

NHS analysts have monitored mortality over time and have not found any evidence that the changes in Newark resulted in increased death rates. The Mail on Sunday analysis was replicated as far as possible, based on the information available to us, but the Mail figures could not be calculated despite several different methods of reviewing the data sets. The CCG analysis and response are included for ease of reference in Appendix 1.

Queries have been raised about why the NHS figures do not match the Mail on Sunday published figures. Death rates can be calculated in a number of ways, with a number of factors taken into consideration. NHS data sets are very large and complex, so conclusions should be validated in a scientific manner before drawing any conclusions. It is possible that there are duplicated cases in the Mail on Sunday article, since cases are reported separately by hospitals and people often move between sites during their episode of care.

Following the changes at Newark Hospital, total deaths (across all settings) do not appear to have changed significantly. There appears to have been a temporary increase in deaths over the summer of 2012 in a number of areas, including Newark. However, these rates have since fallen and the causes for this are not clear. Fluctuations in death rates do occur, hence the need to monitor trends over extended time periods.

Definitive analysis for all deaths by postcode would require the linking of hospital activity data sets with Office of National Statistics data. The Health and Social Care Information Centre do not routinely provide such analysis to the NHS except in relation to each hospital provider.

3. The CCG previously submitted data to the Health Scrutiny Committee that showed no association between travel times to A&E and mortality rates.

Despite this analysis, there is debate about whether travel times to A&E contribute to increased mortality rates across Mid-Nottinghamshire. Postcode areas with the longest travel times do not appear to have the highest mortality rates and it is thought that other significant factors come into play.

A paper was written by Professor Nicholl that appeared to demonstrate an association. However, public health advice is that the Nicholl paper cannot be applied to our local situation. The figures were from 1997-2001, before developments in ambulance and paramedic care on route to hospital. Travel times or road distance were also not assessed. There is no further reference to this issue in the NHS England urgent care evidence base that was published in June 2013.

The ‘golden hour’ concept has also been referred to in the local media. This refers to the first minutes / hours following a traumatic injury. It is well established that outcomes are best if treatment is received within a short period of time following a serious injury. However, there

is no evidence that survival rates decrease after one hour. The major trauma unit is Queen's Medical Centre, which has a wide catchment area for major trauma. Significant treatment at the scene is now also commonplace, so that patients are stabilised as quickly as possible.

4. **The CCG is committed to developing the best possible services for local people, so long as these meet national standards and are affordable.**

The changes at Newark Hospital were made for compelling safety reasons. The latest requirements for emergency care cannot be delivered within the infrastructure of the hospital, but there are many other services that can be delivered to an excellent standard there.

The CCG will continue to work closely with Sherwood Forest Hospitals and with the coordinating commissioners for United Lincolnshire Hospitals and the ambulance service to improve care. This will have great potential benefit for the people of Newark and others who rely on our hospitals.

5. **It is also proposed that we commission a wider review of determinants of local mortality rates across Mid-Nottinghamshire, so that we can best understand how to target our commissioning resources.**

This review would be completed over the summer and would inform the wider Mid-Nottinghamshire transformation programme. **We invite ideas about the scope and remit of the review from the Health Scrutiny Committee and wider public.**

Dr Amanda Sullivan

Chief Officer

Appendix 1

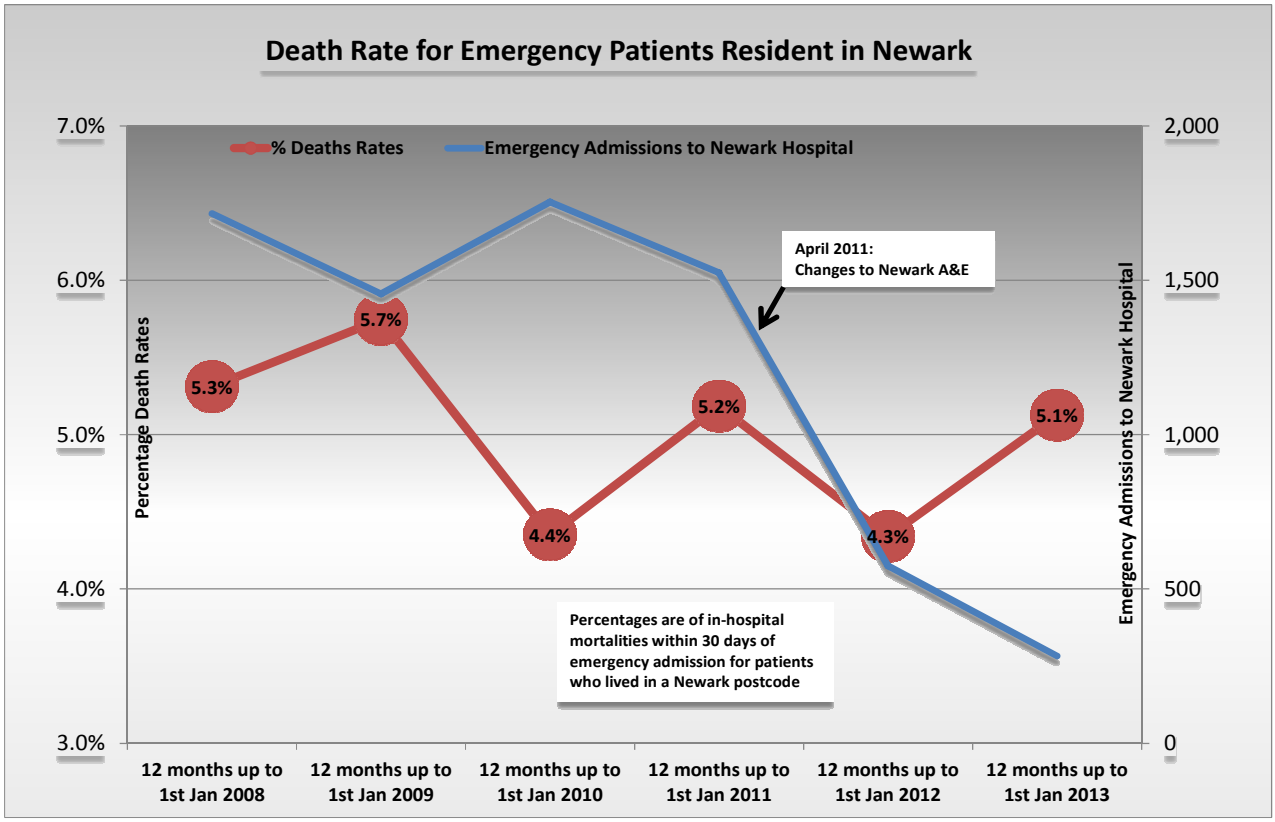
Mortality rates in Newark area

13th May 2013

The chief officer of Newark and Sherwood Clinical Commissioning Group is re-assuring patients following the publication of figures relating to mortality (death) rates in the area.

Amanda Sullivan said: "Figures published in the tabloid press which suggest a sharp increase in mortality rates are misleading and were not validated before they were published. This may have caused unnecessary alarm and I would like to reassure Newark residents that the emergency services they receive from the NHS are safe.

Deaths of patients from the Newark and Sherwood area following admission via A&E are not on the rise. Official CCG figures show that the changes at Newark Hospital in 2011 have not had a negative impact on patient care. We have repeated the analysis carried out by the Mail on Sunday from our official data sources and have validated the results. These clearly show no increase in death rates.



It is also important to recognise the changing mix of patients being admitted to hospital. Overall admissions from A&E are rising across the whole country, partly due to an increasing frail elderly population. Healthcare changed considerably from 2008 to 2012with more patients being treated in

their homes, so that only the very poorly are taken to hospital resulting in a higher proportion of major cases being seen there.

The reclassification of Newark A&E to an MIU in April 2011 was for compelling safety reasons. Newark is a very small hospital (less than 60 beds) and has never had the infrastructure to support a modern A&E service (for example intensive care services and emergency surgery).There is clear evidence that people who have heart attacks and strokes need prompt treatment at a specialist centre, where the specialist staff and facilities are best placed to treat people. Mortality from these causes is on the decline locally. Delaying arrival at a main centre by going to a small hospital for assessment results in poorer outcomes. Furthermore, patients are increasingly treated by ambulance crews at the scene and on route to a main hospital, so time prior to arrival at a main centre is not lost time.

We want to assure our local residents that we continually review information relating to services we commission and take early action to investigate any issues identified. We are working closely with local hospital Trusts on the national Keogh review into mortality rates. “