NATIONAL REVIEW OF HSMR - CONSENSUS STATEMENT

In February this year, we were invited by Sir Bruce Keogh to carry out a review of the use of indicators which can help us to understand variations and trends in regard to in-hospital deaths. Organisations have been using different approaches for monitoring mortality, mostly using variations of tools such as the Hospital Standardised Mortality Ratio (HSMR) and the Risk Adjusted Mortality Indicator (RAMI). However, the different versions of mortality indicators and other assessments of the quality of care can produce different results, and this has inevitably resulted in some confusion across the NHS and the public at large. We were asked, therefore, to look at agreeing a single methodology for a mortality indicator for adoption across the NHS in England, and to offer some guidelines about its use.

We took into account a view that had been expressed by the Department of Health that "A high HSMR is a trigger to ask hard questions. Good hospitals monitor their HSMRs actively and seek to understand where performance may be falling short and action should not stop until the clinical leaders and the Board at the hospital are satisfied that the issues have been effectively dealt with." Not everyone in the review group could subscribe to this view but we considered it helped demonstrate the need for this work to be undertaken.

Our work has now concluded, and our report has been approved by the National Quality Board, and is available at http://www.dh.gov.uk/en/Healthcare/NationalQualityBoard/DH_102954. Subject to a satisfactory outcome from some essential statistical testing and modelling trials, we have proposed that the NHS should adopt a new measure – the Summary Hospital-level Mortality Indicator (the SHMI) .

Our package of recommendations provides a comprehensive and coherent framework for the introduction and handling of the SHMI, including its publication, and continuous review. And recognising that no single indicator will give the whole picture, we offer guidance as to how this and similar indicators should be considered alongside other information.

We propose that the indicator should cover deaths relating to all admitted patients that occur in all settings - including those occurring in hospital and those occurring 30 days post-discharge. It should apply to all NHS acute trusts except specialist hospitals. The SHMI adjusts as far as possible for factors outside of a hospital's control that might impact on hospital mortality rates.. There are some exceptions relating to data quality issues arising from variations in the recording and coding of co-morbidities, and also from variations in clinical coding practice in regard to palliative care, where we believe there is a need for clearer national guidance All these aspects of its design and outputs will be subject to rigorous independent testing and assurance prior to its introduction during 2011.

Our conclusions and recommendations support the aims of the Department, in the context of quality and safety, as well as openness and transparency. A summary hospital-level mortality indicator is one of a number of indicators which can provide important information about a hospital and its quality and, in some circumstances, help shine a light on potential areas for further analysis or investigation. As a high level measure, it is a helpful indicator to have in the portfolio of screening and surveillance indicators and may help flag potential problems, but only if used in conjunction with and corroborated by other information.

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