



On the 5th July we ran a link to the Independent's News paper [story](#) about the Pennine NHS Trust and high death rates.

The Chief Executive, John Saxby was kind enough to take the trouble to write to us and put us in the picture about the work that is going on around this very difficult topic.

We are pleased to publish it as it gives an insight to the Board's thinking and the efforts they are going to, to improve the quality of care at the Trust. It is quite an eye-opener.

Of course publicised high death rates are an issue, a concern and a worry for the Trust. And one that the Board takes extremely seriously and discusses, considers and debates publicly at its monthly board meetings.

For the past c18 months "Patient Safety, including patient experience" has been the first item on the Board's agenda. That way it gets maximum exposure and maximum debate. Mortality is an item under this heading and we have set ourselves and our clinical services, mortality reduction targets as an internal standard.

When Dr Foster published its HSMR data last year a number of Trusts in the North West appeared as outliers on the high side.

Nine of those Trusts formed mortality collaborative and are working together AND with Professor Jarman to get behind the data and establish the true nature of the high SMR.

Few people understand whether a high HSMR indicates a clinical care problem. However as Professor Jarman, and Action against Medical Accidents have said it is an indicator that needs checking out. That is what we are doing.

Whilst we do not believe it is a care problem we have to be certain. Care issues have of course come to light through our investigations and we address these systematically, introduce changes and then audit to be certain that changes in practice are embedded. I am sure

that even Trusts with reported low SMRs do the same. You can always get better.

We have used CHKS as our external data analysts for several years and their HSMR calculations do not place us as a high outlier. Somewhat confusingly and on the contrary they put us a number of points below 100 and reducing.

We know that Dr Foster and CHKS use different methodologies to calculate their respective HSMRs and you will know that there is great debate about the respective merits or otherwise of the different approaches.

Our response is not to get too concerned about those differences but deal with the issues. Let's hope the work being done on HSMRs at national level removes the confusion that has plagued us all and at the very least comes up with a single approach. We will then all be measuring the same thing, even if the issue is still "What to make of it?"

Any patient experience quoted will always be relevant but you will have noticed that the one case mainly referred to in the article involved a patient who died in 2005.

In the other case quoted dating from 2007, the newspaper comment does not cover the case fully but I do have to admit, we failed that patient and have admitted that.

Importantly the investigation of that case, using an external expert to review the care provided has helped us introduce a range of changes in clinical practice to help us better distinguish as the coroner said "between patients whose condition is wholly attributable to alcohol against those who may have sustained a head injury" and he went on to say that "The greater the number of patients who present with alcohol induced symptoms the harder it will be to recognise the unfortunate few who have suffered a traumatic head injury."

It would be a brave Chief Executive who claimed that all is perfect in his or her Trust and I would never make such a claim. What I would be certain about saying is that we look into any and every issue of concern and seek to address them and improve the service we provide to our patients, living up to our mission statement

"To provide the very best care, to each patient, on every occasion."

John Saxby
Chief Executive