A	**A. Introductory questions**
A1	How long have you worked in the trust?
A2	What is your role now? • Was this the same in 20XX when the first mortality alert for sepsis/AMI was received? • What do you see as your responsibility relative to mortality risk?
B	**The local institutional context surrounding the first alert**
	8. Had management, organisation and financial position been stable in the trust over the last five years? [Develop based upon knowledge from prior questions] • If organisational instability was present: What effect did this have on the focus on quality of care and avoidable mortality? 1. In terms of the local context at the time of the (first) alert in 20xx, what was the situation like in the Trust at the time? • Was the trust aware it had a high mortality risk leading up to the alert? 2. Had you received prior alerts in other areas? - What effect did those have? 3. Was the trust part of a quality/safety/mortality improvement programme locally or nationally? • What measures were in place? - SBAR, MEWS, PDSA cycles and run charts? - Care bundles for AMI and Sepsis in use? 4. How was the management of mortality organised in the trust when the alert arrived? – Committee structures, responsibilities, governance, people etc . – High level organisation of governance – Frontline practices and procedures. 5. How was mortality monitored and reported within the trust? What measures and analytic capabilities were in place? 6. Can you comment on the strategic priorities of the Trust leading up to the arrival of the first alert? • What were the local priorities and concerns? - Was reducing mortality high on the list of priorities? - What was the relative priority assigned to quality of care/avoidable mortality compared with productivity, finance and other targets? - What projects were being funded/what initiatives were in place?
C	**Short-term reaction to the mortality alert**
	7. How did you learn about the mortality alert? 8. How were details of the first alert communicated and what message was communicated? • Within the organisation? • Was there an external/public response to the alert and what was it?

9. How would you describe the organisation's attitude to receiving the first alert?
    - e.g. surprise, disbelief, confusion, acceptance, anger, realisation?
    - Was a problem with mortality known about and was the alert expected?
10. What was the specific reaction to receiving the first alert?
    - At board level?
    - Amongst staff groups?
    - Amongst patient groups? Complaints?
    - Was there a media reaction? What effect did this have?
    - Was pressure placed upon the organisation from external agencies? Which/how?
11. What was the view regarding the Dr Foster mortality data at the time?
    - Did you generally agree with the data and what the alert was telling you?
    - Was the data trusted/regarded as valid and reliable?
12. What initial or immediate action was taken in response to the alert?
    - Was investigation instigated into the reliability of the data/coding? Did local data suggest there was a problem?
    - Was there any dialogue with Dr Foster?
    - What immediate actions were taken to safe-guard patients, if any?
    - If having received prior alerts, what effect did this have upon the immediate response this time?

D	**Strategic and long-term response to the mortality alert**

13. How were the priority areas for action established?
    - Were the underlying causes of avoidable mortality easy to establish?
    - What internal/external groups were consulted to inform the response?
    - Who were the key stakeholders in the decision-making process?
    - Was there broad agreement on the way forwards amongst stakeholders?
14. Can you talk us through the strategy developed to deal with the mortality issue?
    - What options were considered?
    - What new processes, groups, structures, roles, committees were planned?
    - What changes to guidelines/practice/systems were planned at a clinical level to address septicaemia/AMI?
    - What education/training needs were identified?
    - Were buildings and infrastructure implicated? How?
    - How was the response communicated internally and externally?
    - How had experience of past alerts/issues informed your response?
    - What existing structures were utilised to mount the response?

15. How was the strategy implemented? How did you go about making changes?
    - How were new structures/groups established and how did they start work?
    - How were educational/training needs met?
    - What measures/data collection mechanisms were put in place?
    - What challenges were encountered in implementing the response/strategy?
    - Was there broad support or resistance amongst stakeholder groups?
    - How were these challenges overcome?
    - Were you able to link in to any broader campaigns/programmes/networks/collaboratives for support in tackling the mortality issue?
16. How effective was the strategy and measures put in place? Was the response generally regarded as a success?
    - How do you know? What evaluation was undertaken? What measures/data was used?
    - Did you monitor the trend in mortality risk? How did it respond to your interventions?
17. How do you currently measure and report on mortality?
    - Do you think you have the right measures in place, do you think?
18. Looking back on all the work that your organisation did to reduce hospital mortality, what were the top three things that you would say had the most impact?
    - If you were asked to advise another organisation just receiving a Dr Foster alert, what advice would you give them?

With the benefit of hindsight, would you have done anything differently?

E Evaluation and impact of mortality alerting system

19. How has the organisation and management of mortality risk changed over time in the trust?
    - What effect did receiving the first/subsequent alerts have upon this?
    - What were the important lessons learnt concerning the organisational response to alerts, do you think?
20. Where would you say reducing mortality sits now in trust priorities?
    - Has this changed since receiving the first alert(s)
    - What impact has the mortality alert(s) had on trust priorities?
    - Has the trust managed to keep a focus on mortality over recent years during all the other requirements to improve services? If yes, how? If not, why not?
21. How would you describe the culture and attitude towards quality and safety now within the organisation?
    - Has this changed since addressing the mortality risk issues highlighted by the alert?
    - How would you characterise the institution's experience of dealing with the mortality issue? Would you say it had been positive or negative?
22. What is the view within the trust concerning the Dr Foster mortality alerts?
    - Is there confidence in the reliability and validity of the data?
    - Are trends in relative risk monitored?
    - How is Dr Foster mortality data used in the trust, if at all?
23. How would you interpret the presence of repeat alerts in the same area?
    - What do you think repeat alerts say about the effectiveness of the local response to the first alert?