Item 3(IIa)

Warwickshire Shadow Health and Wellbeing Board

13 November 2012

George Eliot Hospital - Mortality Report

Recommendation

The Shadow Health and Well-Being Board is requested to comment on this report.

1. Introduction

1.1 George Eliot Hospital has been identified as an outlier against mortality ratings over the years with a higher than expected HMSR. Last October we were identified as having a higher than expected SHMI, being the highest in England. It is expected that the Dr Foster figures of HSMR for the year until March 2012 will continue to show high ratings for this parameter, although both SHMI and HSMR show an improving position.

2.0 External Reviews

2.1 As a direct and immediate response to the increase in HSMR in September 2011 and prior to the October SHMI being released, the Trust put actions in place to undertake a wholesale review of organisational systems and processes.

2.2 **Mott MacDonald**;

2.3 The Trust commissioned an external review, undertaken by Mott MacDonald, who explored potential contributors to mortality statistics and identified four key areas for improvement;

- Continuity of care: Particularly in relation to patient moves between wards and change of responsible consultant
- Patient flow: Need for better pathways for patients to and from primary/community care and the hospital.
- Information management: Need to improve information management systems to support clinical and managerial decision-making and to improve the recording of patient information which can impact the way mortality rates are calculated.
- Impact of external factors on GEH mortality figures: Specifically for end-of-life care in the community and to improve healthy living,

health outcomes and reduce health inequalities within the local community.

2.4 These improvements would be delivered through a number of recommendations and subsequent actions which formed the basis of the Trust's plan, some of which have been implemented immediately, whilst others required continuing work or investigation.

2.5 The report also noted that George Eliot had higher deaths in hospital and at home than the national average, with lower numbers of deaths in hospice and nursing homes. Significantly the report also found that there was no single cause of high HSMR / SHMI i.e. any specific patient group, specialty or diagnosis group.

2.6 **The Royal College and the Association of Surgeons of Great Britain and Ireland**

2.7 The Royal College undertook a service review of colorectal services at the George Eliot Hospital in February 2012, from which we received a positive outcome- concluding that that there were no significant immediate causes for concern with regard to the clinical outcomes of the colorectal surgical service at the George Eliot Hospital.

2.8 **Inpatient census (commissioned by the Clinical Commissioning Group)**

2.9 This work highlighted patient records to be an area of concern and a Task and Finish Group chaired by the Medical Director has been established to improve the quality of recording in the notes and the quality of composition of the medical records.

2.10 **In depth Coding Review**

2.11 This work has just recently concluded and the report is awaited later this month.

3.0 Action Plans

3.1 A detailed action and implementation plan was put in place in response to findings from the above reviews and amalgamated with other actions underway. The detailed action plan is reviewed and updated monthly.

3.2 Actions completed or in train include:

- All inpatient deaths are coded by the consultant responsible for the care in the final illness with subsequent review of the coding by the Medical Director, the Associate Medical Director and members of the coding team.

- Mortality Reviews are carried out on 20 medical deaths per month and all surgical deaths. The reviews are carried out by a buddy consultant and presented to the consultant responsible for the care. Any issues of concern are discussed at a mortality review meeting with the Medical Director and Associate Medical Director.
- Patient moves have been seen to be a key component of diminished care and the number of moves is being monitored and has reduced.
- The management of end of life is being addressed and a Task Group established to improve this process. The Trust intends to join the Route to Success Pilot Programme for End of Life Care and education of staff.
- A sepsis care bundle has been introduced and is being audited regularly to address compliance.
- Investigation of a number of Dr Foster alerts over a period of time have demonstrated inaccuracies of coding and have not demonstrated sub-standard care.
- To facilitate 7 day services, business plans have been approved in cardiology and radiology, an additional cardiologist has been appointed and the interviews for an additional radiologist will be held in November. Work is underway in pharmacy.
- The Trust Board receives detailed information regarding HSMR and SHMI and are fully appraised of the actions and progress on a regular basis, including monthly reports utilising the Dr Foster data.
- Medical and Nursing Directors of both the Trust and Arden Cluster continue to meet monthly to review the action plan. The Chair of the CCG has recently joined this meeting.

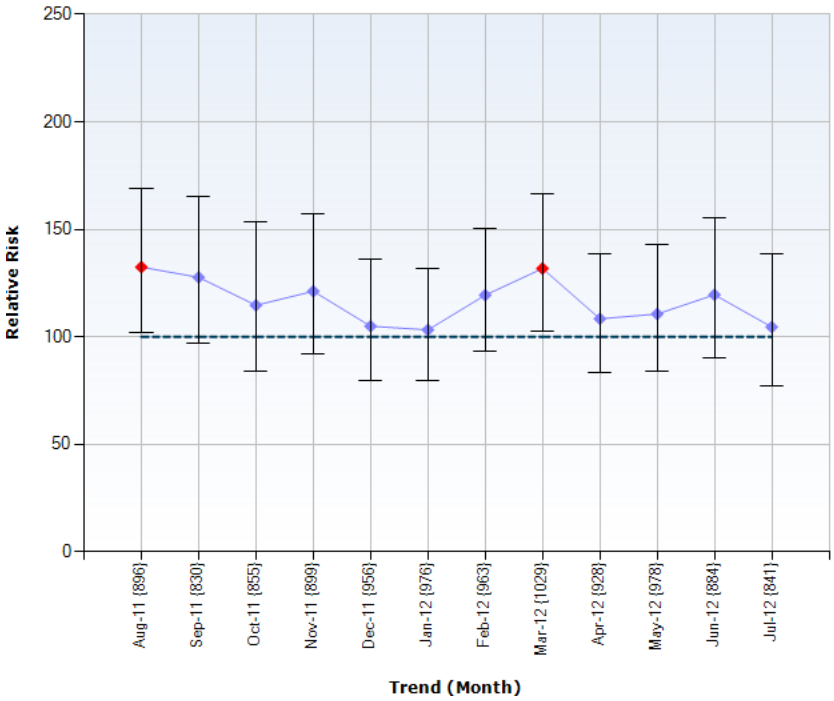
3.3 A summary action plan has been developed as an overview document which identifies the major work streams that are key to the on-going delivery of a reduction in mortality rates at the George Eliot (Appendix 1).

3.4 Underlying all of these actions has been the organisational change resulting in devolved decision making in the organisation. The revision and re launch of the organisations vision, core value pledges and strategic objectives, alongside the introduction of a new divisional structure reinforces this.

4. Progress

4.1 Mortality Rates

4.2 From a starting mortality rate of 117.3 last September, there has been a general improvement in the mortality figures and since March 2012 HSMR has been on a downward trend, but still remains above the benchmark. It is important to note that the current benchmark year is 2011/12 after being rebased in August 2012.



4.3 The current HSMR for August 2011 to July 2012 is 116.0; July 2012's HSMR is 104.5, which is very pleasing although the Trust is not complacent and will need to show month on month improvement. Likewise the recently published SHIMI for 2011/2012 shows that the Trust's figure has reduced from 1.23 to 1.16, again a significant improvement and one that the Trust now needs to build from. However, both the recent HSMR and SHIMI results shows that the work detailed within this report is starting to work and take traction both within the Trust and across the wider Health System.

MORTALITY SUMMARY ACTION PLAN OCTOBER 2012

Area for review	Sub area	Expected Outcomes	Completion /Review	RAG Rating	Comment/ Evidence
1.Clinical	a)Sepsis Bundle:	Implement Sepsis Care Bundle	June 12		Completed. Identified as issue in nursing mortality review, linked to CQUIN 8c delivery in year.
		Completion of baseline audit against sepsis six compliance	July 12		Completed.
		Multidisciplinary launch of Sepsis campaign	Sept 12		Completed
		Improve compliance with sepsis bundle- to include improvements to numbers receiving antibiotics and reduction in time from medical review to antibiotic delivery	Oct 12		Trajectory to be agreed via CQR.
	b)Fluid Balance	Review and change to timings of fluid balance charts with a change to timing of analysis and completion	June 12		Completed. Focus on fluid balance identified through patient safety leaders' work.
		Workshops for nursing home staff planned to highlight nutrition and dehydration management	Nov 12		Internal clinical mortality highlighted issues with admissions from nursing homes.

	c) Escalation & Intervention	Internal in depth clinical review	April 12		Completed
		Track and Trigger system procurement	August 12		Procurement delayed due to challenge from unsuccessful bidder.
		Reduction in trigger point scale for senior review within 60 minutes. Monitor via outreach audit.	Nov 12		Further detail of trajectory/ timeframe to be provided.
		ISOBAR handover tool- Increase interventions, with improved communication, monitor via audit.	May 12		Ongoing review of all areas to ensure core information and implementation maintained. Part of Matron Audit.
		Completion of escalation and intervention "vital" module	Mid October 12		5% remain outstanding. Clear plan in place to reduce over next two weeks. Ongoing for all new starters.
2. Documentation	Medical records	Increase capacity of ward clerks and work to standardised practice	Dec 12 (R)		Reviewing current workforce and redeployment of Band 2 staff as part of capacity changes
		Clear Backlog of filing, splitting of oversized notes and replacement programme	Dec 12 (R)		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
	Record keeping	Compliance with Royal College of Physicians standards	Monthly Audit		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
		Weekly audit of PAS updates	Weekly		Have improved but need to sustain this. Introduction of Track and Trigger system

			review		will resolve issues.
		Nurse sensitive indicators – compliance above 90%	Monthly review		Measured and reported monthly in quality report to Quality Assurance Committee. Tolerance to be increased to 95%.
		Raise awareness of record standards	Sept 12		Led by Task & finish group- chaired by Medical Director (Mott Mc review)
		Establish patient documentation performance measure, add to performance dashboard	Nov 12		Audit tool to be implemented as part of NSI programme monthly.
	Coding	Implementation of outcomes of full coding review when known	Oct 12		Report due later this month.
3. Culture	Nursing/ medical relationships	Roll out of Excel- Trust vision, core values and strategic objectives	Nov 12		Good practice highlighted at Back to Basics and Healthcare Operational Board meetings. Embedded within divisional objectives.
		Ward round project to improve discharge rates and delays in patient flow	Nov 12		Baseline work completed and reported to Execs end of Sept.
	Changes in nursing/ medical practice	Reduction in patient ward moves- based on agreed % trajectory	Oct 12		Linked to CQUIN 8a. To be reviewed Oct 12 by CQRG
		Increase in (all) Incident reporting by 10%.	Jan 13		Red risk as low starting point as reported in NRLS data Sept. Monthly review by governance team. Reporting to Quality

					Assurance Committee.
		Pressure area care- maintenance of PUPs campaign	Monthly review		Reports to Quality Assurance Committee
		WHO Surgical checklist- 100% compliance	Monthly review		Reports to Quality Assurance Committee
		Mortality Reviews of all inpatient deaths by medical and nursing staff- based on agreed review process, audit methodology and assurance mechanisms.	Oct 12		Linked to CQUIN 8d
4. Whole Health Economy	Palliative Care/ End of Life	Increase number of end of life patients on Liverpool Care pathway based on agreed % trajectory as agreed at CQRG	Oct 12		Linked to CQUIN 8b. To be reviewed Oct 12 by CQRG
		Implement outcomes of pilot of RIPPLE	Nov 12		Pathway and documentation developed. Patient testing of process to commence, with review to follow.
		Delivery of Route to Success	Oct 12		OBC to partnership Board, Exec in Oct for sign off at Healthcare Operational Board in November.
	Introduction of 7 day working	Acute: Phased implementation plan with business case for capacity, medical teams, pharmacy, radiology, physiotherapy, occupational therapy and pathology	Dec 12		Further detail of whole health economy involvement to be included.