Agenda Item No 3(ii)

Warwickshire Shadow Health and Wellbeing Board

19 January 2012

Mortality Review – George Eliot Hospital

1.0 Context:

1.1 The George Eliot Hospital has been repeatedly identified as an 'outlier' against mortality ratings over the years, with a higher than expected HSMR. We have more recently been identified as having a higher than expected SHMI, which is the highest in England.

1.2 Over the past twelve months there have been significant leadership changes within the Executive Team at the George Eliot Hospital, specifically with the appointment of a new Medical Director in relation to this issue. The Medical Director is leading a review to fully understand what is causing the George Eliot to record consistently high rates of mortality to provide a reliable conclusion and the implementation of an action plan to ensure robust systems and processes are embedded within the organisation.

1.3 Also in train is the implementation of a revised organisational structure and governance review to increase accountability both managerially and clinically organisation- wide.

2.0 Actions:

2.1 As a direct and immediate response to the increase in HSMR in September and prior to the October SHMI being released, the Trust put an action plan in place to undertake a wholesale review of systems and processes in place, which included;

- Consultants requested by Medical Director to review significant outliers and feedback within four weeks.

- The Royal College and the Association of Surgeons of Great Britain and Ireland have been contacted and have agreed to undertake a service review of colorectal services at the George Eliot Hospital, dates confirmed as February 2012.

- A peer evaluation process will be undertaken between GEH and both a local and national outlier Trust.

- Internal processes for mortality review have been examined and redefined. All deaths are reviewed by a consultant within two days. An initial screening of potential preventable mortality is then undertaken utilising a trigger tool, and reported to the Medical Director and Associate Medical Director within two weeks of death. Any deaths which require further investigation undergo a full screening and in depth review and appropriate follow up with the consultant by the Medical Director. Consultants have been reminded of the importance and timeliness of this work.

- A weekly review of all deaths is undertaken by the Medical Director, Associate Medical Director and Senior Coding Manager to ensure process and systems put in place are followed and maintained.

- An external review is underway by Mott MacDonald of the following potential contributors to mortality statistics;

    1. The quality of medical care and delivery of care at GEH
    2. Coding
    3. The contribution of external factors such as the provision of palliative care in our area and the quality of primary care

    This review commenced in October 2011 and is due for completion at the end of this month. Initial findings include areas for improvement in IT systems and coding, continuity of patient care and the impact of external factors as outlined above.

- Action and implementation plans will be drawn up in response to findings from the above and amalgamated with other actions underway.

- The Trust Board has been provided with detailed information regarding HSMR and SHMI and they have been fully appraised of the actions and progress on a regular basis. A Board to Board meeting with the Cluster is to be arranged.

- We have discussed our actions with Executive Directors from the West Midlands and East SHA and have liaised with the Arden Cluster to keep all our partners appraised of progress.

2.2 The George Eliot Hospital is clear that any remedial action it needs to take to improve quality of care and reduce its mortality figures is being dealt with. But it also needs to be recognised that the GEH mortality figures are a systems problem and the GEH needs support from other agencies. The health statistics for North Warwickshire are significantly worse than surrounding areas, whilst a significant funding gap exists between the North and South of the County.

2.3 With the development of GP Commissioning and the strong supportive but challenging relationships that now exist between the GEH and the emerging Clinical Commercial Groups, we are confident that the overall health of our population can improve.

Kevin McGee
Chief Executive
George Eliot Hospital