GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

LEARNING FROM MORTALITY REVIEWS

Date of meeting	22/03/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Natalie Morgan Thomas – Interim Deputy Head of Clinical Audit and Quality Informatics & Lead Nurse for Clinical Effectiveness. Esther Flavell – Anaesthetic Consultant & Interim AMD Clinical Effectiveness, Mortality Review & Strategy Mathew Smith - Clinical Audit Manager
Presented by	Dom Hurford, Interim Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Leadership Group	07/03/2022	NOTED

ACRONYMS	
MR	Mortality Review
ME	Medical Examiner
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
PoWH	Princess of Wales Hospital

1. SITUATION

- The purpose of this report is to update the Quality and Safety Committee of the way Cwm Taf Morgannwg University Health Board captures and disseminates the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.
- Cwm Taf Morgannwg University Health Board mortality reviews are undertaken in line with the All Wales Learning From Mortality Review Model Framework (September 2021).
- MEs are independent to organisations, HBs and Trusts and will review all deaths other than those that are covered by HM Coroners. They will refer any concerns identified at their initial review, to the relevant Health Board. This provides an objectivity to the reviews undertaken
- Upon receipt of an ME referral, the organisation will decide on the most appropriate process for managing cases that have been sent to them by the ME.

2. BACKGROUND

Baseline Population Numbers

- The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2020 for population of local areas to Cwm Taf Morgannwg University Health Board

Area	Estimated pop 2020	People/km 2020
Bridgend	147 539	588
RCT	241 873	570
Merthyr	60 424	542

- The table below shows the number of deaths per area for each month of 2021 for each local authority area. Again, the data sets are from the ONS using their 2021 dataset.

2021 Number of deaths reported per calendar month by area of usual residence

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	303	137	123	106	99	117	134	108	162	135	147	146
RCT	322	228	224	191	208	175	209	181	243	214	261	257
Merthyr	93	60	67	43	47	55	50	41	52	74	57	57
Total	718	425	414	340	354	347	393	330	457	423	465	460

- The mortality review service looks at small numbers of the deaths included in the data above referred as detailed below. In 2021, 696 cases were referred for review by the mortality panels including medical examiner referrals and stage 1 reviews. Case numbers per area are detailed below.

2021 number of cases referred for further review per area

Bridgend	RCT	Merthyr	Total
214	248	234	696

3. ASSESSMENT

Learning from Mortality Reviews

Stage 1 reviews

- Medical Examiner Service is currently reviewing approximately 85-90% of all Cwm Taf Morgannwg University Health Board, in hospital deaths. The table below outlines the number of deaths for each ILG from 1st April 2021 to 31st December 2021, the number where an initial review has been undertaken (either by ME or UMR), and the number and percentage outstanding.

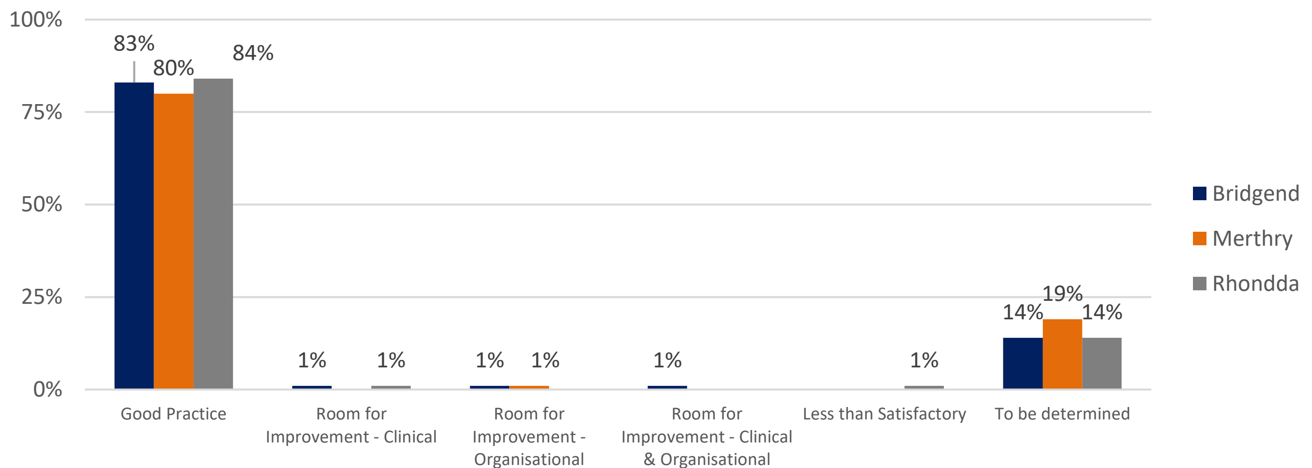
	Total Deaths	Number Reviewed	Number Outstanding	Percentage Outstanding
Bridgend	770	467	303	39%
Merthyr	751	623	128	17%
Rhondda	832	784	48	6%

- **Stage 2 Mortality Review panels**
- The table below shows the number of cases identified for Stage 2 for each ILG from 1st April 2021 to 31st December 2021, the number where the review has been completed and the number and percentage outstanding.

	Number of Stage 2	Number Complete	Number Outstanding	Percentage Outstanding
Bridgend	68	16	52	76%
Merthyr	110	43	67	61%
Rhondda	113	42	71	63%

1.7 Stage 3 Mortality Review panel

Panels are now held monthly via Teams. Stage 3 functionality will be reviewed upon implementation of the Datix Mortality Review Module



- Themes noted at Mortality Review include:
  - Peri-operative Physician - Recent cases within Trauma & Orthopaedics and General Surgery has highlighted a lack of this service within CTM
  - End of Life Care - From recent reviews at all levels of Mortality Review it has been noted that better end life care could be achieved with awareness and training
  - Increased number of patients admitted under inappropriate teams / pathway for initial management.
  - Escalation of Care – continues to be a requirement for improved NEWS recording, escalation and clinical response to escalation.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 The Health Board is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

2.2 **Extrinsic:**

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)
- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins

2.3 **Intrinsic:**

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

Learning Opportunities in place

- Feedback to clinical teams
- Sharing with heads of governance
- Action plans via datix module
- Stage 2/3 reviews via panels and screening tools
- Comprehensive investigation as part of 'putting things right'
- Summary of themes via quarterly newsletter
- Biannual learning events
- Transparency via datix module with access to governance and clinical audit teams

Ongoing Development

- Health Board wide Mortality Review Screening Panel that will be live from April 2022. This will consist of representatives from each ILG (Clinical and non-clinical, Primary Care, Palliative Care, Welsh Ambulance Service and Local Authority
- DATIX Mortality Module will go live April 2022. All mortality review data will be maintained on this system moving forwards.
- Further recruitment of clinical reviewers for each ILG to attend mortality review sessions to undertake mortality reviews in a timely manner. Approximately 75 members of staff across the 3 ILG's have received Mortality Review training.
- Consider appointing ILG Mortality Leads to provide oversight and clinical leadership within their locality
- Ongoing support for the process with allocated time and staff
- Work is in progress to link the findings from the MR process with the Health Board quality improvement programme of work.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Effective Care Dignified Care Timely Care Staff and Resources
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There is a requirement for a dedicated band 5WTE post (£38,204) and maintenance of existing CA&QI funding level to support this function (proposed £70k reduction)
Link to Strategic Goals	Improving Care

5. RECOMMENDATIONS

Committee to **note** the content of this report.