Meeting Date	**24 August 2021**	**Agenda Item**	**4.4**
Report Title	**Mortality Reviews Report**		
Report Author	Alastair Roeves, Interim Deputy Medical Director and Chair of the SBUHB Level 2 Mortality Scrutiny Panel		
Report Sponsor	Richard Evans, Executive Medical Director		
Presented by	Richard Evans, Executive Medical Director		
Freedom of Information	Open		
Purpose of the Report	To provide assurance regarding compliance with the Health Board's Mortality Reviews Process, to introduce the new Medical Examiners Service and the associated national and local arrangements in place to support learning from deaths.		
Key Issues	The Health Board currently requires that all in-hospital deaths are subject to review via the Mortality Review Process, with compliance at Stage One and Stage Two, reported to Welsh Government. The limitations of the current system will be overcome via roll out of the Medical Examiners Service providing independent scrutiny of all deaths and a platform for learning from the bereaved.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE THE CONTENTS OF THE REPORT**			

MORTALITY REVIEWS REPORT

1. Introduction

The report aims to provide assurance regarding compliance with Mortality Reviews at each of the stages, in addition to providing an introduction to the new Medical Examiners (ME) Service, the associated national and local arrangements in place to accommodate the new approach and the information and actions generated.

2. Background

The Health Board's existing Mortality Reviews Process has been in use since 2013 and performance data was required by Welsh Government from April 2017 to March 2021 when notification was received regarding the implementation of the Medical Examiners Service. It is heavily reliant upon junior doctors responding to a set of questions, some of which can trigger a more senior review, at the time they complete the death certificate.

In December 2020, the Care After Death Service was created at SBUHB, incorporating existing Patient Affairs, Chaplaincy and Spiritual Care Teams, Bereavement Counsellors and linking closely with the Mortuary Team. The Service under the remit of the Director of Therapies and Health Sciences, aims to work with Funeral Directors, Local Authorities, the ME Service and the Coroner to expand on the excellent pockets of care provided to the dying and bereaved across the Health Board, ensuring equity across the patch.

The new ME Service for raising concerns about the care delivered in a patient's final illness, went live in Wales in April 2021. MEs, independent of Health Boards, are responsible for completing an Advice and Scrutiny Form within 3 days of receipt of a death certificate and scanned copies of the case-notes.

In time all deaths in hospital or the community, unless already referred to the coroner, will be reviewed in this way. The approach has started with acute hospital deaths on a small scale, until additional staff secured via a successful business case are in place within the Health Board and the ME Service has filled all necessary posts.

3. Governance and Risk Issues

Board assurance framework agreed actions include;

- Medical Examiner Service being rolled-out across Wales with expectation that it will become a statutory function from April 2022. An audit of the mortality review process is planned once the ME system has had an opportunity to bed in (30/09/22)

- A local SBUHB Mortality Review Framework document will be produced, based around the National Learning from Deaths Framework (30/09/2021)

- Content of reports to the Quality & Safety Committee regarding mortality reviews will be reviewed and revised following adoption of the local SBUHB Mortality Review Framework (30/09/2021)

a. Mortality Reviews Compliance

Until the ME Service is rolled out, the existing Mortality Reviews Process and reporting requirements remain. Appendix 1 illustrates current compliance.

The Clinical Outcomes and Effectiveness Group (COEG) receives this performance data and through its membership, specifically the Service Delivery Group Medical Directors, addresses any concerns.

3.2 All-Wales Model Framework for Learning from Deaths

The All-Wales Model Framework for Learning from Deaths, co-written by Dr. Alastair Roeves and the NHS Wales Delivery Unit, has been reviewed by Medical Directors across Wales and is due to be published. It forms the basis of SBUHB's own Policy and will inform the Terms of Reference for the local Scrutiny Panel.

The All-Wales document sets out a framework for the management of ME referrals, over five levels (Appendix 2). In effect, all of the traditional Stage 1 mortality review and most of the stage 2 review is to be completed by the Medical Examiner. When a referral comes from the Medical Examiner, the Health Board deals with this in alignment with *Putting Things Right* processes. At level 1, a clinical lead is allocated to review each case and present to the weekly level 2: SBUHB Scrutiny Panel

3.3 Level 2: SBUHB Scrutiny Panel

A multi-disciplinary group (Appendix 3) has been assembled to screen and review referrals from the ME Service with a view to promoting effective learning across the Health Board, utilising the new ME model and existing processes.

Support for both the Scrutiny Panel and the existing Mortality Reviews Process is provided by the Clinical Audit and Effectiveness Department.

It is not the function of the level 2 Scrutiny panel to investigate a concern. It is the role of the panel to assess the case and determine what further investigation, if any, is needed and by what process, mindful of the limited resources available and the level of harm involved in the case.

In assessing and discussing these cases, the Panel has the option to;

- Close down the review and feed back to ME Service
- Refer the case to the Putting Things Right/Safeguarding process

- Refer the case for a local proportionate investigation under existing Service Group Quality and Safety processes

Appendix 4 provides some examples of cases received and reviewed
Appendix 5 provides an overview of common themes emerging from the Panel reviews.

Of the 159 cases sent to the ME Service up to 9th August 2021, 14% have been referred back. In addition, five cases in which patients died at other Health Boards have been referred to us, having had issues identified from earlier admissions to SBUHB. Neighbouring Health Boards have been able to scan across more or all deaths acute deaths. Across Wales, the average referral rate is 20%.

28 cases have been reviewed by the weekly multidisciplinary panel so far, which means that higher level scrutiny is occurring much more rapidly following a death than under the traditional system.

As the number of cases scanned across to the ME Service from SBUHB increases, careful monitoring will be required on the impact of additional work for the Panel, the turnaround and timely completion of cases and on the Clinical Audit and Effectiveness Department.

The Panel is keen to expand its membership to avoid meeting fatigue amongst the existing members, maintain enthusiasm and ensure continued multi-disciplinary input. There is great interest in the set up at SBUHB, with colleagues from other Health Boards and organisations regularly dialling in to observe.

In time, the completed DATIX Mortality Reviews module being piloted at SBUHB and Cwm Taf, will support thematic reports. These will be reported locally via COEG and upwards to the Quality and Safety Governance Group.

3.4 Level 3: Proportionate investigations

So far, the level 2 panel has requested further investigations involving several routes: here are some examples

- Putting Things Right processes within specific directorates/service groups because of family concerns raised to the medical examiner about the final admission
- Reflective Exercise by a GMS practices on their management of DNACPR in care home residents
- Incident investigation of concerns raised by families about events that occurred several months prior to the final admission

It is clear that the new Learning from Mortality Review process is making the Health Board aware of concerns it simply would not have known about under the old system

3.5 Level 4: Thematic Reviews

It is too early to have reviewed sufficient numbers of cases to have developed any themes. Ongoing Data collection as part of the new process will mean that themes, according to a nationally agreed taxonomy can be identified and reported on.

3.6 Level 5: Sharing Learning

Dr Alastair Roeves and Sharon Ragbetli are supporting the national working groups to develop national and regional/local schemes for sharing learning across boundaries. We will report on these as they occur.

3.7 SBUHB Policy

The local Policy will be completed and issued for comment on receipt of the All-Wales Framework Model document.

4. Financial Implications

None currently.

5. Recommendation

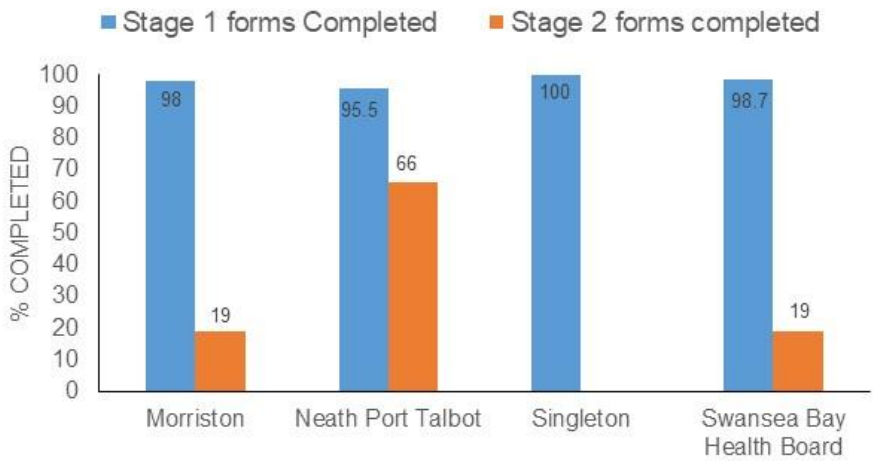
The Quality and Safety Committee is asked to note the report.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Mortality Reviews and the Medical Examiners Service provides insight into the quality of care and experience for those patients in their final illness and the bereaved, offering opportunities for the Health Board to learn, share learning and improve.		
Financial Implications		
None.		
Legal Implications (including equality and diversity assessment)		
None.		
Staffing Implications		
None.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
None.		
Report History	Previously submitted by the Interim Deputy Medical Director with responsibility for Mortality Reviews prior to his retirement.	
Appendices	Appendix 1. Latest Performance Report Data for Compliance with Mortality Reviews Appendix 2. All-Wales Model Framework 5 Levels of Management Appendix 3. Scrutiny Panel Appendix 4. Scrutiny Panel Cases Appendix 5. Common Themes Table	

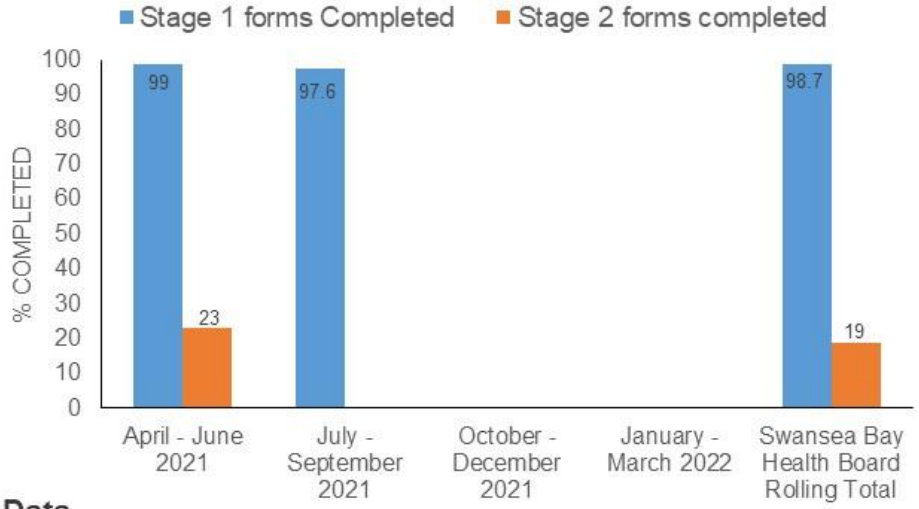
Appendix 1. Compliance with Mortality Reviews

Mortality Reviews Performance Data

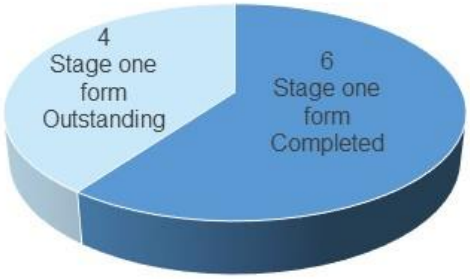
% of Stage 1 & 2 Mortality Forms Completed April 2021 – March 2022



% of Stage 1 & 2 Mortality Forms Completed 2021/2022



Mental Health Information April 2021– March 2022



From the completed forms there were No stage 2 triggers

Thematic Review Data April 2021 – March 2022

(Received/Required)

Medical Examiners Learning from Deaths Information

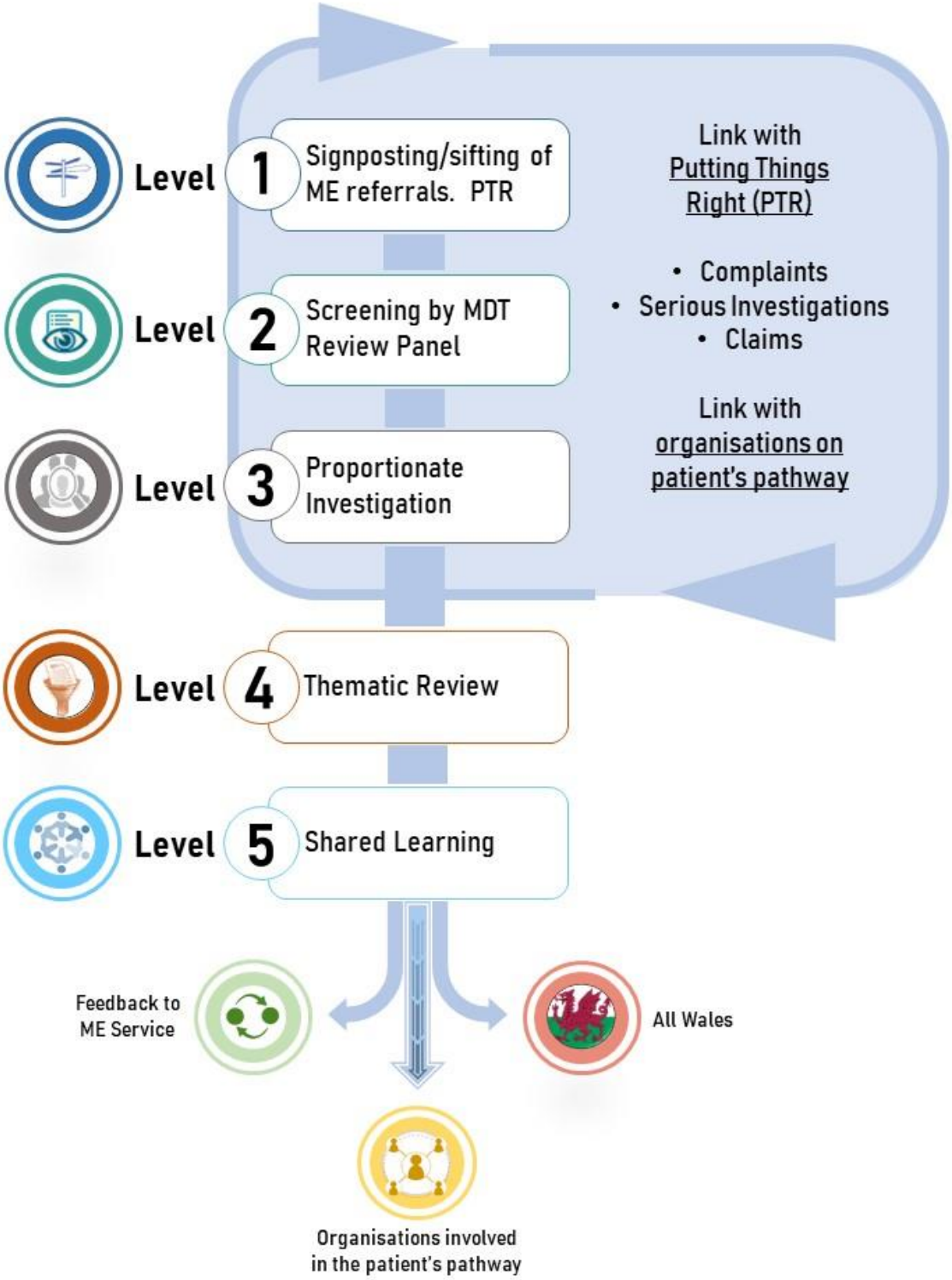
Rolling Data – 12/01/2021 to 08/08/2021

(12/01/2021 – 30/04/2021 - Morriston deaths only)

(01/05/2021 – 08/08/2021 – Morriston & Singleton Deaths)

Number of:-	From 02/08/2021 to 08/08/2021	In Total
Deaths	37	949
Cases sent to ME	6	159
Referrals raised by the ME	3	27 (5 from other HBs)
Referrals closed down by panel	1	21
Referrals still open	0	6
Feedback Completed	0	18

Appendix 2. All-Wales Model Framework 5 Levels of Management



Appendix 3. Scrutiny Panel

Alastair Roeves, Interim Deputy Medical Director

Sophie Down, Interim Legal Services Manager

Nigel Downes, Head of Quality and Safety, Corporate Nursing

Ruth Emanuel, Head of Physiotherapy

Susan Ford, Patient Feedback Manager

Hazel Lloyd, Head of Patient Experience, Risk & Legal Services

Sharon Rağbetli, Clinical Audit & Effectiveness Manager

Paul Swithenbank, Lead Clinical Pharmacist, Neath

Erica Thomas-Howells, Concerns Assurance Manager

Yvette Lee-Matthews, Clinical Audit & Effectiveness Facilitator

Hannah Evans, Legal Services Manager

Rhian Newton, Head of Prescribing & Medicines Management, Neath

John Terry, Head of Pharmacy, Neath Port Talbot Hospital

Sowndarya Shivaraj, General Practitioner, Primary Care

Gemma Eccles, General Practitioner, Primary Care

Sue Morgan, Consultant Specialist Palliative Care & End of Life Lead for the Health Board

Leigh Keen, Welsh Ambulance Service Trust Clinical Lead SBUHB

Craig Barrington, Clinical Oncologist, Clinical Oncology

Shelley Horwood, Quality & Safety Manager, Mental Health & Learning Disabilities

Appendix 4. Scrutiny Panel Cases: examples

1. Concern from ME's ***"Family have raised concerns regarding unsafe discharge from Morriston Hospital"***

The Panel established that there were no concerns relating to the care during the last admission, but that they stemmed from a previous admission and a potential unsafe discharge. It has been confirmed that a multifactorial complaint has been received and that the Physiotherapy Department have responded to the Complaints team.

The Panel were able to close the case from a Mortality Review point of view in light of the fact that it is being dealt with through the stance as being dealt with through an existing Putting Things Right (PTR) process

2. Concern from ME's ***"Family concerns regarding patient management across two Health Boards – ME confirmation of potential failings in care and HMC referral"***

The Panel established that there were no concerns about care during last acute admission, but with a potential error in laboratory processing of a sample during a previous admission episode at SBUHB resulting in delayed scanning and radiotherapy.

Via the screening process the Patient Feedback Manager had already made contact with the family regarding bereavement support and to provide information on the new Panel process. The concerns are to be dealt with under the Putting Things Right (PTR) process

3. Concerns raised ***"Was the fracture missed on admission or did it occur in-hospital? It was picked up clinically"***

The Panel established that documentation from the Consultant Geriatrician stated that the patient was confused, had Dementia but was moving all limbs. Documented working diagnosis of evolving frailty.

Following complaints of pain a few days after admission, the patient was transferred to Morriston for a CT scan. The results showed an impacted fracture of right neck of femur however, the report stated that they were not convinced that this was a recent fracture.

The patient's health deteriorated over the 3 weeks spent in hospital, with the patient refusing physiotherapy treatment, food and drink.

Comprehensive set of notes was viewed in addition to physiotherapy notes and DATIX records indicated there was no evidence of a fall.

The Panel agreed were satisfied that there was no evidence that fracture occurred whilst in hospital and were unable to ascertain the age of the fracture, noting multiple factors which pointed to it occurring before hospital admission. The case was closed and information shared with the Hip Fracture Task Force.

Appendix 5. Learning from Mortality Reviews: Common Themes Table

Themes	Running Totals
Compliments to be fed back to service	1
Concerns re: Last Hospital Admission	0
Concerns re: Transfer between hospitals	0
Concerns re: WAST	2
Concerns re: Medication	0
Concerns re: Safeguarding	1
Concerns re: Outpatient Chronic Disease Management	0
Concerns re: HB Community Services	0
Concerns re: GMS(GP) Chronic Disease Management	0
Concerns re: GMS(GP) Acute Care Management	0
Concerns re: Communication	5
Concerns re: Documentation	1
Concerns re: From Previous Admission	2
Concerns re: Raised from family NOT ME	1
Update local policy	1
Update National Guidance	1
PTR	1
DNACPR	1