Meeting Date	**25 May 2021**	**Agenda Item**	**4.3**
Report Title	**Internal Audit Report –Mortality Reviews**		
Report Author	Dr Alastair Roeves		
Report Sponsor	Dr Richard Evans		
Presented by	Dr Richard Evans		
Freedom of Information	Open		
Purpose of the Report	This paper is to report on the findings of the Internal Audit review and outline the steps being taken to deal with the issues identified, and describe the rapidly changing environment for conducting mortality reviews.		
Key Issues	1. SBUHB is developing formal policies and procedures describing expectations to avoid inconstant practice in mortality reviews. 2. Stage 1 reviews are being completed in a timely manner, to be replaced by the Medical examiner Service 3. Stage 2 reviews should be completed in a timely manner, and backlog has been cleared and work absorbed into a new weekly multidisciplinary Mortality Review Panel. 4. Lessons learned from reviews should be identified. 5. The COEG is meeting and scrutinises audit reports. 6. The QSC should be provided with assurance that reviews are taking place and that any lessons learned are resulting in positive actions.		

Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	The Quality and Safety Committee is asked to note: • the progress being made to adopt innovative approaches to mortality reviews, leading national development on several fronts, and also supporting the roll out of the Medical Examiner Services for Wales, the Once for Wales Concerns Management System, and the National Learning from Deaths Framework. • the findings of Internal Audit report • the resulting actions are being interpreted and implemented in the light of this rapidly changing environment.

Report on Implementation Plan following Internal Audit of Mortality Reviews

1. INTRODUCTION

Internal Audit repeated an audit of mortality reviews as a component of the 2020/21 audit plan for SBUHB. Previous Internal Audit reports have derived 'Limited' assurance ratings. While preparations are made ahead of the introduction of the Medical Examiner Service, there is an ongoing need for timely review of patient deaths and learning of lessons where applicable.

2. BACKGROUND

Traditional Mortality Reviews

Since 2010, the health board has adopted processes to undertake reviews of all in-hospital deaths. Where prompted by concerns identified within an initial review performed by a junior doctor, a second stage review is undertaken by senior clinician. These second stage reviews are then discussed within the service, and may lead to a thematic review. Deaths in Mental Health and Primary Care were not included.

This methodology can lead to accusations of 'marking your own homework', and failing to look beyond the final admission. There was little evidence of learning linking in to the wider strategic function. The process of scrutiny is a 'trigger tool' methodology where records are reviewed using a series of increasingly fine 'sieves' or tools. There is also concern over lack of standards for conducting stage 3 'thematic' reports, leading to variability of quality.

Stage 1 reports have generally been completed promptly, (currently 100% completion rate as on April 2021) but at times large number of uncompleted stage 2 cases have accumulated. Over the last 2 years, all these cases have been completed and although there were some delays in stage 2 reports often due to an inability to locate the medical records, the SBUHB position has greatly improved. Outstanding stage 2 reviews are now being diverted to the new SBUHB Mortality Review Panel to avoid delays.

SBUHB has developed an electronic mortality review system (eMRA) for recording and monitoring traditional reviews. The template used for traditional Stage 2 reviews has been developed nationally.

All Wales Medical Examiner System

In 2020, the roll out of the All Wales Medical Examiner Service began. Mortality reviews will be performed by doctors who are specially trained and independent of the health board. 23 Medical Examiners across Wales have been recruited and they, together with their supporting officers, will review comments from attending clinicians, families and the medical records of the deceased within 24-48 hours of death. They will eventually review <u>all</u> deaths in Wales, regardless of site of death, and replace all of the initial stage reviews of the traditional system, and some of the second stage functions. Delays in national implementation mean that it is only partially operational in SBUHB. Currently, the first stage review remains the responsibility of the health

board except where the medical examiner has conducted it. The outcome of this initial review stage determines whether a second stage review is required as before.

SBUHB's After Death Service

As the Medical examiner service grows, there is a simultaneous development of the new SBUHB 'After Death Service' which aims to improve the experience of the bereaved following the loss of a loved one. Currently, the medical records of one death per day in Morriston and one death in Singleton are being scanned and sent securely to the Medical Examiner Service. SBUHB's active development of the scanning service has been praised as exemplary by the Lead Medical Examiner for Wales. Medical examiners have direct electronic access to the GP records by national agreement.

SBUHB Mortality Review Panel

SBUHB is pioneering an innovative approach to the review of all concerns raised by Medical Examiners. The second stage is anchored in a panel of senior clinicians from a wide range of fields and professions including primary and secondary care, medical, nursing, therapies, cancer, palliative care, and the legal/patient feedback teams. Meeting as a weekly multidisciplinary screening panel, it reviews those concerns and any existing investigations, and considers what proportionate investigation is required in response, taking a wider view beyond a hospital or professional boundary. It then ensures thematic reviews are conducted to capture learning and shares wider across the health board and nationally. The panels are led by interim Deputy Executive Medical Directors, Dr Alastair Roeves and Professor Aidan Byrne.

The weekly meetings started in April 2021 and have already established that the issues raised by Medical Examiners are very different from those identified by traditional reviews. This is partly related to an incident investigation methodology, rather than 'trigger tool', and the fact that the Medical Examiner service communicates directly with clinicians and families who can raise concerns about any aspect of care, from any time, not just the last admission.

Processes are being development as 'learning in action' as experience grows in this new review methodology.

National Learning from Deaths Framework

Under the leadership of Dr Chris Jones, Deputy CMO, a national group is overseeing the development of a National Framework for managing mortality review processes within Health Boards in a consistent manner. SBUHB is represented by members of the Clinical Audit Team, Legal & Patient Feedback team, and also Dr Alastair Roeves. The Multidisciplinary panel process being piloted by SBUHB is the basis of this National Framework. Learning from SBUHB is being shared with the national development group, and in particular that the SBUHB Framework is aligned to the Concerns and Redress Regulations (Putting Things Right) with its key timescales and communication requirements.

Once for Wales Concerns Management System

This new version of the DATIX database for management of concerns and incidents has just gone live in SBUHB in May 2021. A module to replace the local electronic

mortality review database is being developed and this is expected to be based on the current SBUHB module.

Internal Audit Report
Internal Audit reviewed processes focussed on the traditional methodology as the Medical Examiner Service, After Death Service and Mortality Review Panels and Framework were all being introduced during the audit period.

The Internal audit gave **limited** Assurance
The recommendations were:

1. The HB should have formal policies and procedures describing expectations to avoid inconstant practice.
2. Stage 1 reviews should be completed in a timely manner.
3. Stage 2 reviews should be completed in a timely manner.
4. Lessons learned from reviews should be identified.
5. The COEG should become functional and scrutinise audit reports.
6. The QSC should be provided with assurance that reviews are taking place and that any lessons learned are resulting in positive actions.

Management Response 1	**Responsible Officer / Deadline**
The formal introduction of the National Medical Examiner Service has been delayed with no official start date at present. The process for scanning records after death across the Health Board is in pilot phase, and the Medical Examiner system is not yet fully operational locally. Consequently, the Mortality Review Framework and its associated protocols will need to be tested as the demand for higher level scrutiny increases and adapted to local and national learning. 1. The Draft Mortality Review Framework will be reviewed **monthly** at COEG and adapted as necessary. 2. Progress on this development will be reported to the QSC **quarterly**	Dr Alastair Roeves Dr Aidan Byrne (ongoing) 1. 1st May 2021 2. 1st July 2021

Postscript 1
1: The Mortality Review Framework is already in place and the weekly Mortality Review Panel meetings are occurring. The meetings report to the monthly COEG.

Management Response 2	**Responsible Officer / Deadline**
1. The SBUHB Mortality Review Framework will describe how Medical Examiner concerns are to be reviewed promptly	Dr Alastair Roeves Dr Aidan Byrne 1. **Completed** 2. 1st.June 2021

2. Any outstanding stage 2 reviews from 2020/21 will be taken through the new SBUHB Mortality Review Framework process as test cases within Quarter 1 of 2021/22.

Postscript 2:

2: The weekly mortality review panel is already working through outstanding stage 2 reviews

Management Response 3	Responsible Officer / Deadline
The SBUHB Mortality Review Framework will define which deaths will require a stage 3 review, and how learning will be shared and recorded. The Framework will be adapted according to learning as described in Management response 1: actions.	Dr Alastair Roeves Dr Aidan Byrne (ongoing) 1st July 2021

Management Response 4	Responsible Officer / Deadline
1. The COEG has included the monitoring of mortality reviews in its Terms of Reference and its workplan. 2. The QSGG Terms of reference will include the expectation for COEG to report into it 3. Any Mortality Review report for submission to a group or committee will describe performance, outcomes, an assessment of preventability, remedial actions and learning at Health Board-wide level 4. The COEG/QSGG will submit Mortality Review Reports every quarter to the QSC 5. The QSC Committee chair will be requested to include a report on mortality reviews at quarterly intervals	Dr Alastair Roeves. (Completed) 1. 1st May 2021 (Completed) 2. 1st June 2021 3. 1st May 2021 4. 1st July 2021 5. 1st May 2021

3. GOVERNANCE AND RISK ISSUES

The potential risks of poor quality mortality reviews are as follows:

- Lessons may not be learned if the review of deaths is not comprehensive;
- Delays in completion of reviews may reduce the effectiveness of the process and lose the opportunity to act promptly where there are lessons to be learned;
- Sub-optimal practices may continue if improvements are not made where required and these are not shared more widely where beneficial; and
- There may be a lack of assurance if Board or Committees are not adequately informed of the effectiveness of the process and outcomes.

4. FINANCIAL IMPLICATIONS

No significant financial implications.

5. RECOMMENDATIONS

The Quality and Safety Committee is asked to note

- the progress being made to adopt innovative approaches to mortality reviews, leading national development of mortality review infrastructure and processes, and also supporting the roll out of the Medical Examiner Services for Wales, the Once for Wales Concerns Management System, the After Death Service, and the National Learning from Deaths Framework.
- the findings of Internal Audit report
- the resulting actions/implementation are being interpreted and implemented in the light of this rapidly changing environment.

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
All deaths within the health board should be reviewed and any lessons identified and findings shared.
Financial Implications
No financial implications.
Legal Implications (including equality and diversity assessment)
Failure to adhere to the processes described will inevitably lead to claims due to a failure to discharge our duty to provide a safe environment for patients.
Staffing Implications
None
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
None

Report History	This Internal Audit report is a follow up on previous audits.
Appendices	Appendix 1 SBUHB Mortality Reviews Final Report