Meeting Date	**28th January 2020**	**Agenda Item**	**3.3**
Report Title	**Mortality Reviews**		
Report Author	Aidan Byrne		
Report Sponsor	Richard Evans		
Presented by	Richard Evans		
Freedom of Information	Open		
Purpose of the Report	Clinical reviews are a mandatory requirement to ensure any lessons are identified and shared. The process has involved three stages: 1. Initial screening. 2. Secondary review to identify any concerns 3. Thematic review to identify patterns/learning across a site. The organisation requires assurance that this process is completed effective and any learning shared.		
Key Issues	Historically, the review process has not been completed in a timely manner in all cases, with a significant number of cases uncompleted after more than five years. The Executive Medical Director has discussed with Delivery Units and the longest waiting cases have been reviewed by the Deputy Medical Director. The number of historical cases has decreased and will be expected to be cleared in 2 months. Current stage 1 completion is around 100%. Stage 2 completion is around 35% after 1 month, but >90% after 3 months. This appears mainly due to the unavailability of notes.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: Note the report		

UPDATE ON MORTALITY REVIEWS

1. INTRODUCTION

The completion of mortality reviews is a mandatory process which seeks to ensure that any complications of healthcare are identified, their causes investigated and any lessons learned shared with staff.

2. BACKGROUND

The current process has been in place for many years and consists of three stages.

i. Review by responsible clinician to review if there were any unexpected complications.
ii. Review by an independent clinician to assess the quality of care.
iii. Review by Unit Medical Director to identify any thematic / learning issues.

Although the process is supported by a member of the audit department and has an effective electronic reporting system, it has not been possible to ensure timely completion by all the relevant clinical staff.

3. GOVERNANCE AND RISK ISSUES

The completion of this process is essential, both to ensure that potential complication are identified with remedial actions taken where possible and to provide assurance to the board that medical complications are avoided.

Failure to complete the process poses a risk to patients in that avoidable complications may go unrecognised, with corrective actions not taken. A failure to be assured of the robustness of the system has been noted by the Internal Audit department.

Current stage 1 completion is around 100%. Stage 2 completion is around 35% after 1 month, but >90% after 3 months. Timely availability of clinical casenotes for review is the principal constraint to the reports being completed within 1 month.

4. FINANCIAL IMPLICATIONS

The financial implications of this process are limited to possible fines or litigation for not completion.

5. RECOMMENDATION

The current position is improving, with further improvement anticipated. The current system will be replaced by a new system involving coroners‘ officers in the near future. It is recommended that current actions continue.

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

The review process is essential to safe care. Once we are reassured that the system is functional, we will focus on ensuring that deaths are discussed at monthly audit meetings, to ensure rapid feedback to clinical staff.

Financial Implications

There are no major financial implications.

Legal Implications (including equality and diversity assessment)

As stated above, this process is mandatory and failure to complete the process both risks patient health and opens the health board to risks of litigation.

Staffing Implications

There are no staffing implications.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

This system is a small part of an effective quality and safety process/culture within the organisation. Its value lies in its ability to identify individual and patterns of healthcare failure.

It will only provide effective assurance once the findings of the reviews are fully integrated into an active audit and quality assurance system.

Report History	There have been no recent reports.
Appendices	Appendix 1 - Latest edition of the new format report is attached.