Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 August 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mortality Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Phil Kloer, Medical Director & Deputy CEO
SWYDDOG ADRODD: **REPORTING OFFICER:**	John Evans, Assistant Director, Medical Directorate

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides an update on the mortality review process implemented across the Health Board and a position statement on the mortality indicators that are being reported, together with actions that are being taken to demonstrate improvement.

Cefndir / Background

The Board receive a regular report on the Tier 1 mortality indicators. The targets are:

- Mortality reviews should be undertaken within 28 days (stage 1 – Universal Mortality Reviews)
- 12 month improvement on:
  - Crude mortality rate for persons under 75 years old
  - Deaths within 30 days of emergency admission for a heart attack (patients aged 35 to 74)
  - Deaths within 30 days of emergency admission for a stroke
  - Deaths within 30 days of emergency admission for a hip fracture

QSEAC requested assurance regarding the 28 day target for stage 1 universal mortality reviews (UMR), and also the process for stage 2 reviews.

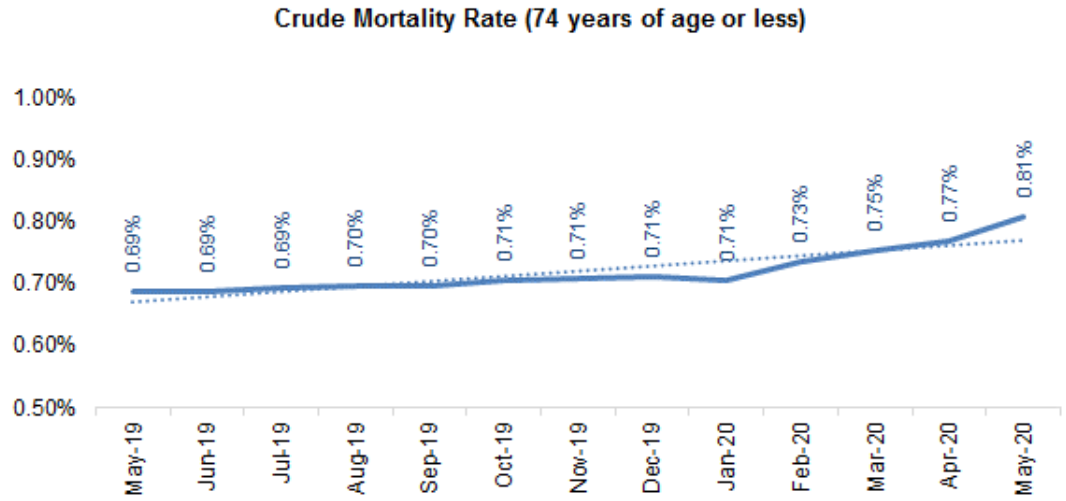
Mortality is one of the indicators used to measure quality of care, however the dimensions of Health Service quality include safety, patient centred care, timeliness, equity, effectiveness and efficiency. Mortality information needs to be considered within this context and alongside other information about service quality including other outcome data, harm, patient satisfaction and experience information, access information and measures of end of life care, etc.

Hywel Dda UHB was the first Health Board to instigate a mortality review process in 2010 in all four acute hospital sites, and the review process was extended to mental health deaths. Welsh Government has been developing a more formalised approach to the mortality review process, splitting it into a Stage 1 and a more detailed Stage 2 process. In August 2018, HDdUHB instigated a new process for Stage 1 reviews in line with other Health Boards in Wales, which

has improved the timeliness of these reviews. Stage 2 mortality review processes routinely take place, and a formal written process has been approved by the Mortality Review Group and QSEAC, and has been adopted by all sites.

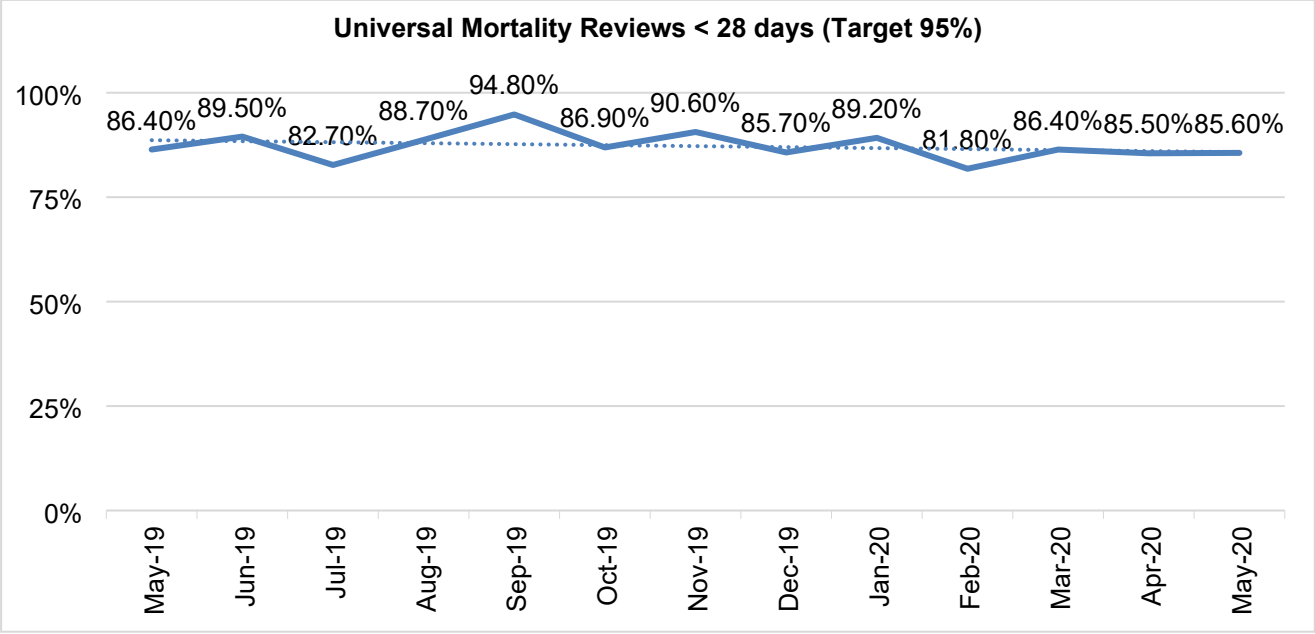
Asesiad / Assessment

Crude mortality rates for patients <75 years had improved consistently since September 2018. Since March 2020, the Health Board's crude mortality rates for patients has reflected the impact of the COVID-19 pandemic, the effects of which (until May 2020) are presented below:



1. Stage 1 performance – Universal Mortality Reviews

The Mortality Review Group, a group of the Effective Clinical Practice Group focuses on the actions required to improve Universal Mortality Review figures. Universal Mortality Review figures are maintaining the recent performance however not yet at the 95% target, with 85.6% of case notes being reviewed within 28 days during May 2020, which is up from 48.5% in August 2018.



2. Medical Examiners Update

The Medical Examiner Service is hosted by NHS Wales Shared Services Partnership (NWSSP) and will provide an independent scrutiny of all deaths that are not investigated by the coroner. Scrutiny will be undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death is recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

The Implementation Programme in Wales is aiming to deliver a single Medical Examiner Service, covering a population of circa 3 million people, via four Regions (North Wales, Mid & West Wales, South Wales Central and South East Wales). Each Region will scrutinise between 5,500 and 9,000 deaths per year. The model being deployed is in line with the National Medical Examiner Good Practice Guidance, utilising dedicated Medical Examiners, supported by dedicated Medical Examiner Officers (MEO) working under delegated authority, both employed independently of Health Boards.

The all Wales Medical Examiner Service will strengthen safeguards for the public by providing robust, systematic and independent scrutiny of all deaths not referred directly to the Coroner, and ensuring the correct deaths are referred to a coroner. The medical examiners review will encompass the current Stage 1 mortality review process and provide intelligent analysis and system level reporting of potential issues found during scrutiny. The service also ensures that the bereaved are given the opportunity to ask questions or seek clarification from an independent medical professional about the certified cause of death or care given during the last illness.

The first stages of the implementation of the Mid & West Wales Medical Examiner Office, covering Hywel Dda and Powys, commenced on 20th July 2020 and includes the following:

- The Medical Examiner office is based in Lanngennech;
- The office and cases are managed by 3 MEOs (Intensive Therapy Unit (ITU) nurse, Clinical Audit Facilitator, Mortuary / bereavement assistant) and a Senior MEO (ITU nurse);
- We have appointed 5 Medical Examiners – Senior doctors; 2 from primary care and 3 from secondary care;
- We have developed relationships with local stakeholders to determine how the service can be moulded around current practices to ensure a seamless service for the bereaved;
- We have begun undertaking Medical Examiner scrutiny on a selection of cases from Prince Phillip Hospital & Withybush General Hospital with expansion to Glangwili and Bronglais General Hospitals planned for the next few months.

Argymhelliad / Recommendation

The Committee is asked to:

- note the holding of performance of Stage 1 reviews;
- note the update on the implementation of the Medical Examiner service.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.9 Provide assurance to the Board in relation to its responsibilities for the quality and safety of public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	631 - Failure to recognise increasing mortality rates. 79, 80, 233, 241, 598, 241, 607, 614, 661 – Risks relating to stroke services 105, 107, 117, 118, 119, 120, - Risks relating to Cardiology services 690 – Clinical management of orthopaedic patients in WGH
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	n/a