Agenda Item: 3vii

Report to:	**Board of Directors**	**Date: 7th February 2019**
Report from:	**Clinical Governance Manager Clinical Lead for Clinical Governance on behalf of the Chief Nurse and Medical Director**	
Principal Objective/ Strategy and Title:	**GOVERNANCE: Mortality Case Record Reviews Patient Safety, Effectiveness of Care, Patient Experience and DIPC**	
Board Assurance Framework Entries:	**Unable to provide safe, high quality care BAF numbers: 742, 675, 1511 and 1878**	
Regulatory Requirement:	**CQC**	
Equality Considerations:	**None believed to apply**	
Key Risks	**Non-compliance resulting in poor outcomes for patients and financial penalties**	
For:	**Information**	

The completion of the rapid retrospective case record review (RCR) spreadsheet and outcomes has been undertaken for quarter 3 and a summary provided below.

Between 01/10/2018 and 31/12/2018 there have been 44 in hospital deaths. Of these 38 met the national criteria for case record review.

26 deaths have either been through the RCR process.
2 deaths have been through a Mortality and Morbidity (M&M) meeting but not RCR process
2 deaths have been through the Serious Incident process (SI) but not RCR process

Speciality	Total	Subspecialty	RCR	SI	M&M	Total
Cardiology	12	Interventional	8	1		9
	1	Electrophysiology	1			1
Surgery	16	Cardiac surgery	11		2	13
	1	PTE	1			1
Thoracic Medicine	1	RSSC *(motor neurone disease)*	1			1
Transplant	7	Heart/Lung/VAD/Tx Assessment/Heart Failure	4	1		4
Total in hospital deaths meeting national criteria	**38**		**26**	**2**	**2**	**30**

Rating of care – Rapid Case note Review

All 26 of the completed Rapid Case Note reviews had a rating of care completed.

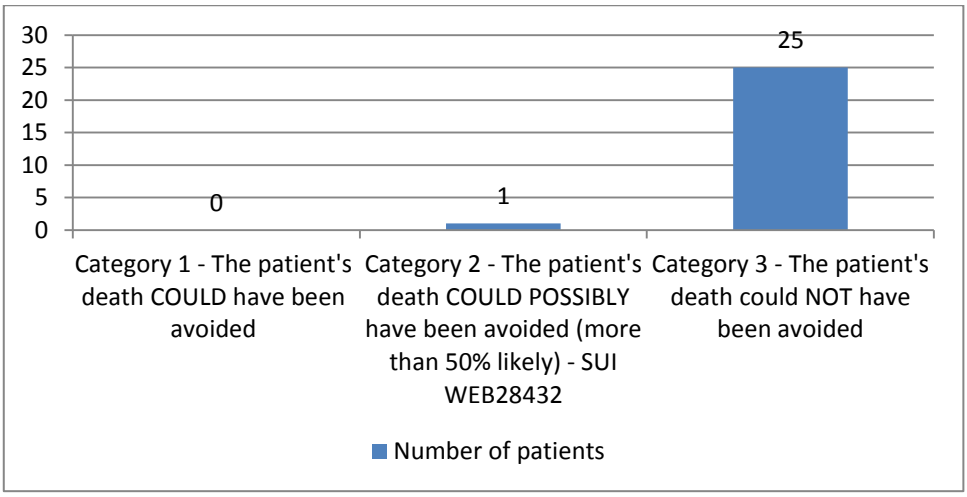
Rating of care for RCR+	1 Very poor	2 Poor	3 Adequate	4 Good	5 Excellent	N/A
Admission and Initial Care			1	4	21	
Ongoing care			1	9	16	
After an operation or procedure			6	10	5	5
End of Life care			1	8	1	2 -N/A due to sudden death 14 – blank
Quality of case notes	3	1	8	6	8	

Rating of care – Surgical M&M
National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) grading system for overall standard of care is used at the surgical M&M meeting. In Q3 there were 2 deaths that did not receive at RCR review but were discussed at the Surgical M&M. Both these cases received a rating of NCEPOD 1 – Good Practice

Rating of care – Serious Incidents
There were 2 SIs investigated in Q3.

- SUI-WEB29215 – Cardiology – Lack of follow of abnormal ECG - still under investigation and therefore the rating of care and mortality avoidability is ungraded.
- SUI-WEB28432 – Incorrect medical device the investigation indicates that the death could possibly have been avoided. Actions are being monitored through the Critical Care Business Unit and Quality & Risk Management Group.

Category of mortality avoidability for 30 of deaths which have either been through an RCR, SI or M&M process



Challenges to process

- There still remains a multifactorial issue with the Current Activity Folder (CAF) being sent to HRD and then scanned into EMR.
- There is not one electronic patient record, therefore information has to be sourced from multiple locations, for example CIS, Lorenzo, VitalPak, CAF, EMR.

Improvements in Q3

- Overall improvement in the number and timeliness of RCR reviews
- Protected time reintroduced for surgical and Cardiology M&M meetings to promptly discuss learning from deaths.
- A business case prepared to bid for charitable funds for Datix IQ module for mortality
- Learning from other institutions – Governance team met with Deputy Medical Director at CUH to discuss their process and lessons learnt. To attend regional learning from deaths event March 2018.

Actions for Q4

- Need all deaths discussed at M&M to be forwarded to Governance team to enable monitoring of data
- Establish if all M&M meetings grade the overall rating of care
- Produce Q4 and annual report for Rapid Case Note Review
- Planned meeting with Governance Team at NWAFT to review their mortality review process.

Recommendation:

The Board of Directors is requested to note the contents of this report