MORTALITY STATISTICS, MORTALITY REVIEWS AND NATIONAL CLINICAL AUDIT

In Wales, all Health Boards and Trusts have been publishing their mortality data every 3 months. This has included some data about the health of their populations, and some more local data about 30 day mortality rates for conditions, for elective and non-elective surgery and in A and E departments. For the local mortality data, making comparisons between hospitals is not appropriate, because the mortality rates will vary depending upon the demographics of the populations and the acuity of the patients seen.

Health Boards have always used mortality statistics to help understand the quality of care in a hospital including the Risk Adjusted Mortality Index in Wales. The extent to which statistics and in particular, a single number, can be used to sum up the quality of care across a whole hospital has been questioned and increasingly doubted. Professor Palmer was asked by the Welsh Government to undertake an independent review of the risk adjusted mortality data for Welsh Hospitals, and consider whether it could provide a meaningful measure of the quality of care in a hospital. In June 2014, Professor Palmer reported that he thought the RAMI could be misleading and was therefore not a meaningful measure of quality. He concluded that there were other ways of understanding the quality of care in a hospital, which included:

- Full participation in National Clinical Audits of individual clinical specialties. These compare the service, the care and treatment and the outcomes in a hospital to evidence-based standards.
- Review of the medical records of all deaths in hospitals following national protocols, with timely, meaningful feedback to continuously improve clinical practice.
- Use of condition specific mortality ratios within a Health Board to monitor changes.
- Improvement in the accuracy and depth of the coding of the care of every patient in hospital – which is the basic data every hospital uses to record, understand and monitor who is admitted to hospital and what care and treatment they receive.

Below, we describe how we are using these methods to understand the quality of care in our hospitals.

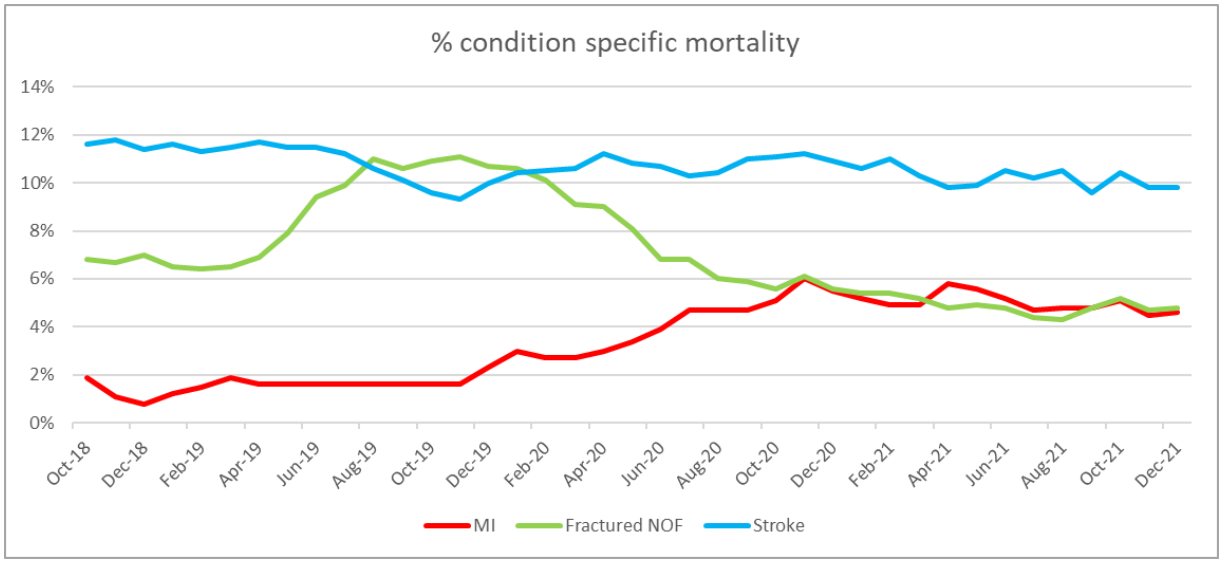
The methods described below are considered in conjunction with other sources of information about patient experience, including complaints and incident reporting, surveys, real time electronic feedback and focus groups.

National Clinical Audit

Many of the Clinical Specialties in hospitals across Wales and the UK participate in National Clinical Audit (NCA). These audits measure health Board services against evidence based standards and the results identify areas of good practice and performance, but also areas where improvements are required. Scrutiny of National Clinical Audit data supports a focused approach to addressing requisite improvements.

Condition Specific Mortalities

The mortality rates for some specific conditions are reviewed through clinical audit and quality and patient safety systems and monitored in the sub groups of the Patient, Quality, Safety and Outcomes Committee.



Data Quality

It is well recognised that robust data can inform Health Boards about the quality and outcomes of patient Care. This data is achieved by using a standardised national set of codes to record the diagnosis and interventions provided during every episode of inpatient care. This allows analysis and benchmarking of care against national organisations.

Medical Examiners

In response to the requirements contained within the Coroner and Justice Act 2009, the a statutory Medical Examiner (ME) Service is being implemented out across England and Wales and will provide the following functions:

- To provide independent scrutiny of all deaths not investigated by a coroner
- To ensure accurate and reliable death certification
- To ensure that the right deaths are reported to the Coroner for the right reason
- To detect problems in care and to pass these onto the health Care provider with information to assist with learning and improvement
- Provide an opportunity for the bereaved to ask questions about the medical Cause of Deaths

The Service is being implemented in response to a number of sentinel events including the conviction of Harold Shipman and the findings of the Gossport Inquiry, Mid Staffordshire Inquiry and Morecambe Bay Inquiry, which between them called for the introduction of Medical Examiners. This recommendation was accepted by the UK Government and changes to the Coroners and Justice Act 2009 has allowed Welsh Ministers to develop their own regulations on the appointment of Medical Examiners, as well as managing, hosting and funding of the system.

The advent of Medical Examiners offers an opportunity for NHS Wales to look at how mortality reviews can be conducted to maximise learning, prevent future harm and improve the experience of patients, families and NHS staff. Many concerns leading to the need for a mortality review are likely to involve multiple professions and services. A national Framework has been developed that will support a co-ordinated and systematic all wales approach to the mortality review process to enable local and national implementation of learning.

This Framework aims to support NHS organisations in Wales in ensuring that:

- A mortality review process is in place that covers every sector of the patient care pathway, so that concerns raised in relation to one sector will be addressed even when the death occurs in another sector and where more than one organisations is involved
- There is a clear structure, governance process, and consistency across Wales for undertaking MRs providing a whole system approach to learning from mortality reviews.
- An integrated approach to the management of risk is implemented, which uses the analysis of linked data to target key areas of concern.
- All areas of healthcare will be included in the review processes conducted by organisations so that the review follows the patient pathway throughout the episodes of care.