The West of England Academic Health Science Network
Mortality Review Collaborative -
A briefing note for patients and the public

All acute trusts have systems in place to ensure patient safety and quality of care. Many of these include ways of reviewing hospital deaths, often by detailed review of the case notes, to identify areas that could be improved. In the West of England we have decided to go one step further.

A national project led by the Royal College of Physicians is introducing a standardised approach to the review of patient deaths. The West of England Academic Health Science Network (AHSN) has agreed to lead a project with our local acute hospitals as the first area in the country to roll out this programme of work. A team consisting of clinical representatives from 8 acute trusts, General Practitioners (GPs) and members of the public are working together with the Royal College of Physicians and the Yorkshire and Humber region where the process of 'structured case record review' was developed.

What this means is that in the future there will be a single national system for collecting mortality data, analysing it and learning from the outcomes. The aim is to improve understanding and learn about problems in care that *may* have contributed to a patient's death. The programme will also identify common themes, enabling closer work between the West of England AHSN and healthcare colleagues to address deficiencies in patient care that are identified and, through continuous quality improvement, share best practice.

Reviewing in detail the records of patients that have died can impact positively on all future patients through reducing rates of complications in care, length of hospital stay and readmission to hospital. The programme will also review the subject of End of Life care and ensure that regionally the best approach is adopted for patients and their families.

Christine Teller, A public contributor involved in the project says:

'As a public contributor on the Mortality Review Steering Group we are, in partnership with our colleagues from the acute hospital trusts and the West of England AHSN (who have initiated this project), pleased that the importance of the public voice in informing the valuable work of the group is recognised. Together, we aim to ensure that a system which reviews all deaths of elective patients and a proportion of those admitted as an emergency is established by all acute hospital trusts in the West of England, so that learning from such reviews, results, as appropriate, in improved health services delivery'.

Ann Remmers, West of England Academic Health Science Network:

"It is vital to us that the voices of patients and their families are heard as we develop and implement this new system to ensure that there is every opportunity to learn lessons from patient deaths and to share that learning across our health systems"

For further information on the mortality review project please contact Kevin Hunter, WEAHSN Patient Safety Programme Manager on 0117 900 2413 or kevin.hunter@weahsn.net or alternatively visit the WEAHSN website at www.weahsn.net