West of England
Academic Health
Science Network

Mortality Review Train the Trainer

Friday 7th October 2016

Holiday Inn Filton, Bristol

1 Overview

About the West of England Academic Health Science Network

The West of England AHSN is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

Established by NHS England in 2013, we are one of 15 AHSNs across England established to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

Each of the 15 AHSNs across England 'host' one of the 15 Patient Safety Collaborative teams, tasked with tackling the leading causes of avoidable harm to patients.

About the event

The Royal College of Physicians (RCP), in partnership with the Royal College of Nursing, AvMA and Datix have developed a standardised approach to mortality reviews. The West of England AHSN and 6 acute trusts, in collaboration, have agreed to be one of the early implementers of the structured review and to develop a best practice framework as a template to support the trusts in this project.

The rollout is planned in 2 phases, with 3 early implementers leading with the remaining trusts following in spring 2017. Two trusts from outside the West of England locality have also asked to join the collaborative.

Concentrating attention on the factors that cause deaths will reduce complications, length of stay and readmission rates. This is through the mechanism of improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient.

Retrospective case record review will identify examples where these processes can be improved and it will be possible to gain an understanding of the care delivered to those whose death is expected and inevitable. In many organisations this group of patients does not receive optimal care, often because the diagnosis (i.e. this person is dying) is not made or the necessary expertise is in short supply

2 How the day was delivered

The programme was a full day of information exchange and interactive learning, based around a core of undertaking two case record reviews and was delivered in an informal setting. The day was led by Dr Andrew Gibson, Consultant Neurologist at Sheffield Teaching Hospitals NHS Foundation Trust and Professor Allen Hutchinson, Emeritus Professor in Public Health at the University of Sheffield.

After a brief introduction by Ann Remmers, Andrew and Allen proceeded to take us through the day and some of the hot topics to be discussed.

The first part of the day involved a discussion and presentation of the structured judgement reviews process, followed by the first of two case note reviews being undertaken in small, mixed professional, groups. There was an opportunity to feedback on the findings and approach adopted.

Following a very nice lunch, Andrew and Allen discussed how to make use of the data available and briefly looked at some good examples of good quality reviews. This was followed by the second case note review session, before the final session on the support and links with the Royal College of Physicians Programme.

3 Input from the room

Group photo of attendees

44 attendees were in the room with representation including ED consultants, consultant physicians & surgeons, specialty doctors, nursing staff, GPs and quality/safety leads.

4 What our participants said

Word cloud from attendees' comments

68% of attendees returned feedback forms, and overall 96% of respondents rated the event as Satisfactory or above. 96% of respondents would recommend the workshop to others in their organisation and 100% of respondents rated the venue as satisfactory or greater.

Attendees really valued the opportunity to get together to discuss their processes, how to carry out a structured case note review, as well as some of the examples used.

Some comments from attendees include: "Like the practical sessions and case reviews", "Good overview of mortality reviews", and "A very good day thank you".

There were a number of suggestions for how future events could be run including "More time to look and discuss case notes", "earlier start and finish times", "more time for discussions", "more case note examples" and "more practical tips on how to digest the notes". These suggestions will be fed back to the trainers and RCP and incorporated into future events we host in the West of England.

5 Outcomes and next steps

A second train the trainer event will be delivered in spring 2017 and will be aimed at those trusts in the collaborative who are not the early implementers. Individual Trusts will be taking the information garnered from the day and have some discussions internally as to their organisational next steps. The collaborative steering group will then discuss the next steps at the regional level.

Thank you to everyone involved in the day!