Oxford
Patient Safety Collaborative

Mortality Reviews

Evidence suggests that 3% of deaths that occur in healthcare settings could be classed as avoidable. Recurrent problems can be prevented by identifying themes and generating quality improvements for care systems. In response to this and several high-profile cases (e.g. Mid Staffordshire, Southern Health), and the Care Quality Commission's report *"Learning, Candour and Accountability"*, the National Quality Board developed national guidance on learning from deaths.

This includes implementing structured case record reviews & investigations (if appropriate) of deaths and to learn and identify themes for improvements in care systems.

The Oxford Patient Safety Collaborative has established a regional group with partner trusts to:

Improve the standardisation of mortality review processes within the community, mental health and secondary care settings and support the development of quality improvement projects based on thematic learning.

In its first year, the group aims to:

- Develop a regional screening tool for acute and community settings.
- Develop a regional network and forum.
- Develop quality improvement as a result of thematic learning from reviews.

The Oxford Patient Safety Collaborative will also be hosting one of the four national Patient Safety Fellows for 12 months to support this work. The Fellow will be collaborating with the four other AHSNs in the South region: West of England; Kent, Surrey & Sussex; South West and Wessex.

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"Its good to be sharing ideas and solutions"

Stakeholder feedback

National Mortality Review

Royal College of Physicians

West of England Academic Health Science Network

The AHSN Network

NHS Improvement

Leadership
Culture
Capability
Learning
Measurement
Process
Innovation

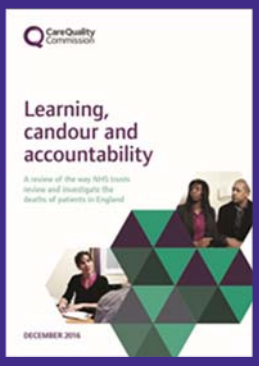
A true example of collaboration …

A collective ambition to develop safer and more reliable systems of care, learn from excellence & errors and reduce avoidable harm has driven this programme forward.

In the Oxford PSC region, the variety of engaged stakeholders is wide. There are 33 key stakeholders:

from:
6 acute trusts
3 community trusts
2 mental health trusts
4 CCGs

representing:
Lead clinicians
Managerial staff
Governance
Patient Safety
Resuscitation
Critical Care
Paediatrics
Learning Disabilities
Palliative Care



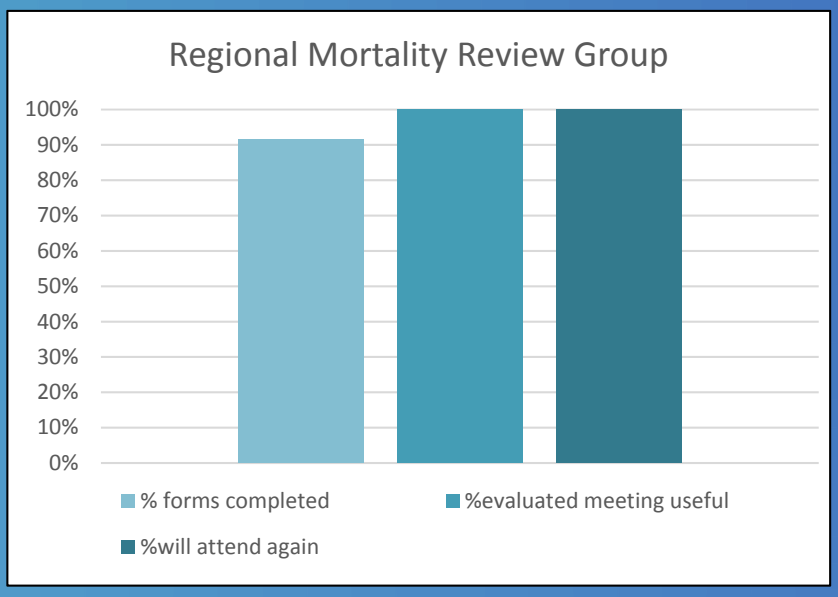
The CQC report: *Learning, Candour and Accountability*.

The RCP's *Structured Judgement Review Method Guide*.

Training - the Oxford Patient Safety Collaborative has facilitated more than 50 regional clinicians and managers in their training on the Royal College of Physician's Structured Judgement Review Tool. Key learning is also being provided to this group by the West of England Academic Health Science Network who were early implementers in this programme of work.

All 15 PSCs are looking to support one another in developing regional and national Communities of Practice in relation to mortality reviews.

The Regional Mortality Review Group has been established since December 2017. All those that attended recognised the importance of unifying the review process and involving other disciplines to implement a review tool that is fit for purpose regionally.



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