Agenda Item
7.2

Quality, Safety & Experience Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Esther Flavell – Clinical Lead for Mortality Review Mark Townsend –Head of Clinical Audit and Quality Informatics Matthew Smith –Mortality Review & Learning Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)		

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HMR	Hospital Mortality Review
ME	Medical Examiner

1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All Wales Learning From Mortality Review Model Framework and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

1.2 The table below outlines the number of ME referrals received (as of 24th October 2025), since the introduction of the Datix Mortality Review Module on 1st April 2022 the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Screened - pending Dashboard update	Under Investigation/ Action Required	Closed
CTMUHB	**4411**	**78 (2%)**	**49 (1%)**	**85 (2%)**	**4199 (95%)**

Learning from Mortality Reviews

1.3 Medical Examiner Service is now reviewing all of CTMUHB, in-hospital deaths and deaths in the community setting since September 2024.

1.4 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. An in-house target has been set of completion within 28 days of the decision made by CTMUHB Screening Panel that a HMR is required.

The table below shows the number of cases identified for HMR since 2022-23 (as of 24th October), the number where the review has been completed and the percentage completed within 28 days of screening panel.

	Number of HMR	Number Complete	Completed <28 days of Screening
2022-23	619	618* (99%)	11%
2023-24	373	373 (100%)	84%
2024-25	376	358 (95%)	67%
2025-26	113	58 (51%)	16%

***1 case recently added as was missed initially by ME service**

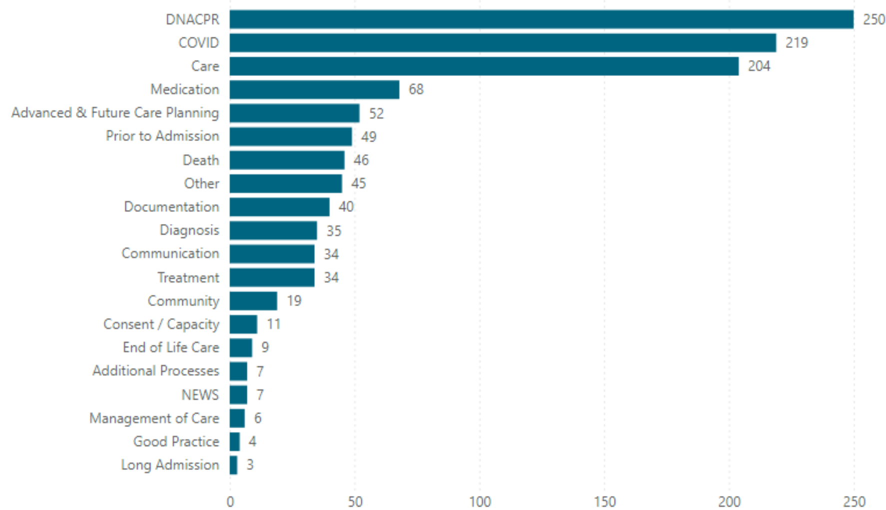
1.5 Completion of HMR <28 days has dropped due to a shortage of HMR reviewers, and historic good will funding for 2 regular reviewers stopping end of March 2025. This has resulted in longer completion times and a backlog of cases accruing. We are now also undertaking an HMR for every in-hospital death where notified that a Coroner's Investigation or Inquest is

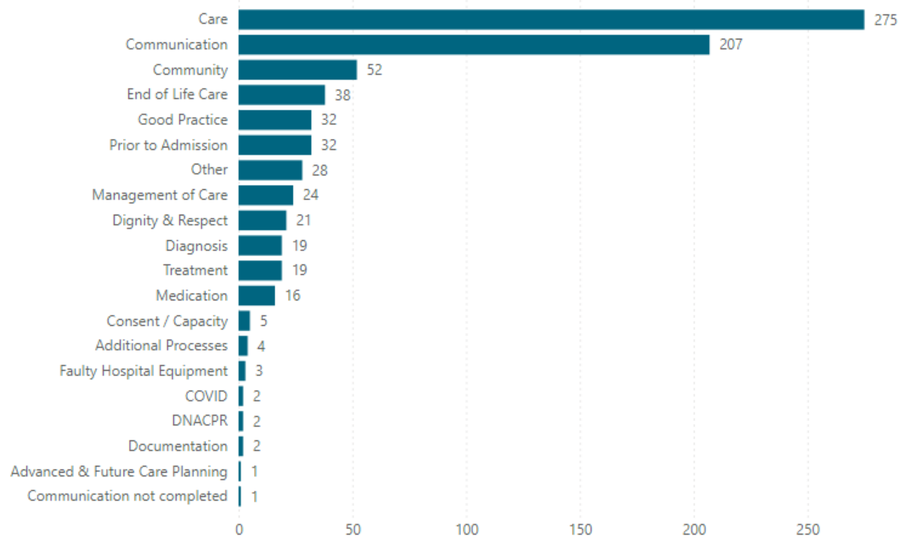
taking place. October 2025 has also seen a significant spike in Hospital Acquired Covid cases, that will further increase the current backlog (currently 74 cases).

1.6 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 4 cases either waiting to be reviewed or in progress.

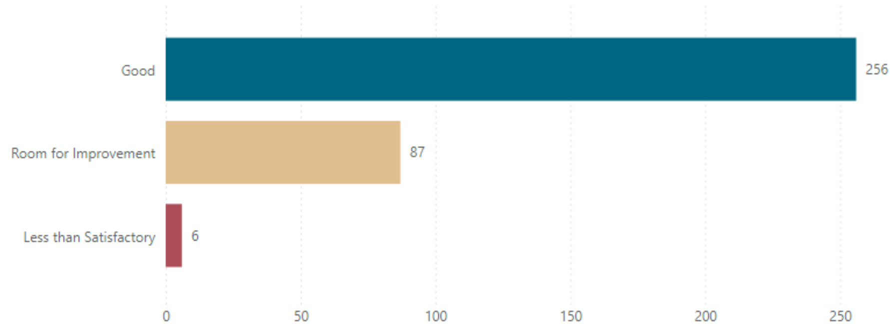
1.7 Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. A Themes database separate to the Datix Mortality Review Module has been created to capture this and feed into the Mortality Review (MR) Dashboard that is currently in development stage. This has given us the opportunity to differentiate between themes from issues noted by the Medical Examiner themselves or the family/next of kin during discussions with the Medical Examiners Service.

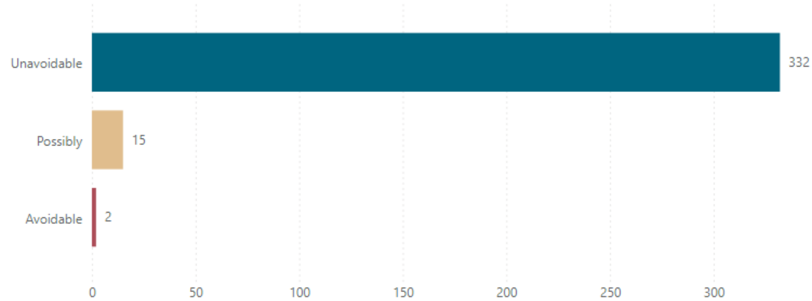
The following charts have been taken from the MR Dashboard. It is important to note the dashboard is still at an early development stage and the data is yet to be fully tested. Due to IT issues we are currently unable to add data for deaths in A&E and Primary care. This is being investigated.



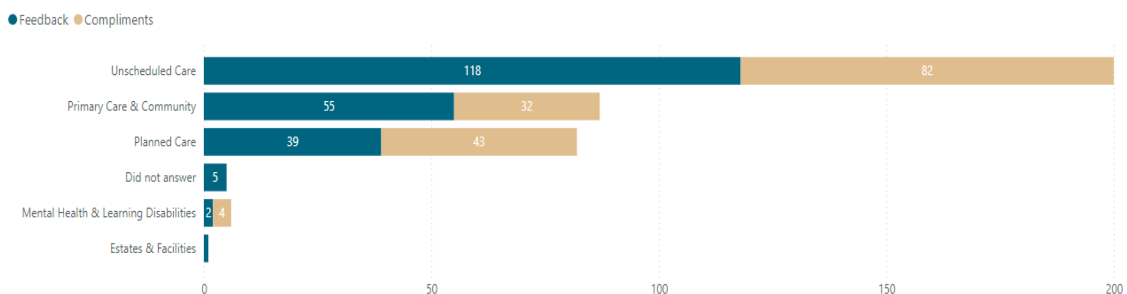


1.8 Current CTMUHB Mortality data shows that there is room for improvement in care in around 26% of deaths.





1.9 CIVICA form has been developed to capture next of kin feedback noted in Medical Examiner referrals. Care Groups/Departments can view specific feedback related to their areas, facilitating targeted improvements as well as capturing compliments and the things that we do well to learn from and build upon. This gives us an understanding of a family/patient and their journey, and an opportunity to have the details of their experience within our health care system. Data has been captured in this system since August 2024.



Mortality Board

1.10 An oversight Mortality Board has been established that oversees and receives assurance that processes are in place to learn from all deaths.

Membership includes, Medical Director, Deputy Medical Directors, Primary Care Medical Director, Clinical Lead for Mortality, Assistant Director of Nursing and Peoples Experience, Mortality Review Manager, Senior MR/Quality Informatics Facilitator, Bereavement Clinical Lead, Mortuary/Bereavement Manager, Head of Peoples Experience, Operations Lead, AHP Representative and Medical Examiners Service Representative.

The Board meets quarterly, and oversees;

1) Data & Dashboard
2) Medical Review Process
3) Learning from Mortality
4) Patient / Family Experience
5) Medical Examiner link

Initial actions required with timescales:

- Standard Operating Procedure (SOP) for Screening Process – Awaiting formal approval
- Governance meeting template for Specialties completed
- Approval of Mortality Review Dashboard – awaiting IT sign off

Ongoing Development

1.11 Whole Mortality Data - Work continues to develop a Mortality Database to collate all information related to Mortality across the Health Board. This is currently in development in partnership with colleagues in Cardiff & Vale and developers from AMaT (Audit Management and Tracking). Current plans are for this to function alongside the existing Datix Mortality module

1.12 Use of an external company to provide peer matched data to compare trends and causes of death on different sites and specialties. This will help to identify outliers and target in-depth analysis of cases and themes. The care groups will take ownership of this analysis and will report to the mortality board.

1.13 QR codes for notifying deaths to both the coroner and the medical examiner service have just been introduced. These aim to reduce the time taken to notify and therefore, reduce waiting time for families.

Baseline Population Numbers

1.14 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2021 for population of local areas to CTMUHB

Area	Estimated pop 2021	People/km 2021
Bridgend	145,500	580
RCT	237,700	560
Merthyr	58,800	528

1.15 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

1.16 The following table shows the number of deaths per area for each month of 2024 for each local authority area. Again, the data sets are from the ONS using their 2024 datasets.

Deaths per region 2024(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	169	142	164	158	147	117	138	143	117	147	132	
RCT	294	257	227	248	240	202	250	216	179	264	210	
MCT	53	65	67	67	65	70	62	67	54	52	59	

ONS data for deaths per month for Wales 2024

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3032	86	2.8
Feb	3072	93	3.0
March	3574	44	1.2
April	2891	27	0.9
May	3195	41	1.3
June	2710	36	1.3
July	2649	78	2.9
August	3043	102	3.4
September	2360	38	1.6
October	2679	56	2.1
November	3292	67	2.0

2. Specific Matters for Consideration

2.1 The Committee is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)
- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins
- Discussions with other health boards and ME services to improve communication and feedback

2.2 **Intrinsic:**

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- Continue to involve clinicians at an early stage for reflection
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. Key Risks / Matters for Escalation

3.1 Limited clinical reviewers with appropriate MR experience available in each Care Group remains challenging, and the biggest risk to the non-completion of the MR process.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Dying Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below: Effective, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: Not required

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 That the Committee **NOTE** the contents of the paper.

6. Next Steps

6.1 Continuation of current Mortality Review Process
6.2 Continued development of Datix Mortality Module at an All-Wales Level.
6.3 Continued development of CTMUHB Mortality Dashboard and use of the data from the external company
6.4 Monitoring of the use of the QR codes for notification to reduce delays for families
6.5 Continued development of Whole Mortality Database