Mortality Reviews
Final Internal Audit Report

April 2024

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for Mortality Reviews.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- An overarching policy and procedure has not yet been developed by the Health Board due to the All- Wales Learning from Mortality Review Model Framework not yet being finalised;
- There is currently a backlog of cases referred back to the Health Board by the Medical Examiner Service which are awaiting internal review and closure. The Health Board aims to clear the backlog by March 2024; and
- There are a number of key priorities that need to be implemented by the Health Board in order to further develop the mortality review processes.

Report Opinion

Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	The Health Board has appropriate policies and procedures in place setting out the mortality reviews process	Reasonable
2	Robust processes are in place for interacting with the Medical Examiner Service	Reasonable
3	Cases referred back to the Health Board by the Medical Examiner are subject to appropriate review in each Clinical Board	Reasonable
4	Adequate review and reporting and to ensure lessons are learned	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policies and procedures	1, 2	Design	Medium
2	Review of cases not up to date	3	Operation	Medium
3	Implementation of Key priorities for the Learning from Mortality Group in 2024	2, 3 & 4	Operation	Medium

1. Introduction

1.1 The audit of Mortality Reviews was undertaken and completed in line with the 2023/24 Internal Audit Plan for Cardiff & Vale University Health Board (the 'Health Board').

1.2 In 2013 the Chief Medical Officer for NHS Wales recommended that all patients who die in a hospital in NHS Wales have a mortality review. The purpose of the reviews is to generate learning about the quality of care and treatment and to identify and act on any concerns in the post-Francis era of candour.

1.3 The Medical Examiner Service for Wales provides independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to His Majesty's Coroner.

1.4 The Medical Examiner Service has been created because it has been recognised that an independent scrutiny of a death, undertaken by a Medical Examiner, who is a qualified and trained doctor but who is independent of any care provided and the organisation who provided it, allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

1.5 The Medical Examiner Service for Wales has been operational and covering all areas of Wales since 1 January 2021, scrutinising deaths that have occurred both in hospital and in the community. However, the impact of COVID 19 meant that the capacity required to scrutinise all deaths in Wales not referred directly to a Coroner was not reached. The UK Government passed the required legislation for the scrutiny of all deaths not referred directly to a coroner by a medical examiner to be a legal requirement from April 2023. The Service in Wales continued to build up its capacity and capability in line with that timeframe. That did not necessarily mean that all appropriate deaths would be scrutinised by a Medical Examiner by April 2023, but that this would be the case as close to that date as possible.

1.6 A Quality Indicators – Progress Report is reported to the Health Board's Quality, Safety and Experience Committee which includes data on mortality[1].

1.7 The relevant lead Executive Director for the review is the Medical Director.

Audit Risks

1.8 The associated risks for the review were:

- Inadequate compliance with Welsh Government requirements to complete and report mortality reviews; and
- Threats to patient safety / opportunities to improve mortality rates are not identified or addressed / implemented.

[1] https://cavuhb.nhs.wales/files/board-and-committees/quality-safety-experience-committee-2023-241/2023-05-09-qse-papers-v6-pdf/ pg 29

2. Detailed Audit Findings

Objective 1: The Health Board has appropriate policies and procedures in place setting out the mortality reviews process and interaction with the Medical Examiner Service.

2.1 The Health Board does not currently have an overarching policy and procedure in place which details the mortality review process. There is an All-Wales Learning from Mortality Review Model Framework in the process of being developed by the NHS Executive which details the role of the Medical Examiners and the Health Boards and how it interacts with other processes such as Putting Things Right. ***(Matter Arising 1 – Medium Priority)***

2.2 There is a page on the Health Board's intranet on the role of the Medical Examiner Service. It also provides an introduction to the Learning from Mortality Group and there is a link to the Medical Examiner Services webpages.

2.3 The Primary, Community and Intermediate Care (PCIC) Clinical Board and Bereavement Services have both developed flowcharts for specific areas of the mortality process. In addition, the Bereavement Services booklet for next of kin has been updated to explain the role of the Medical Examiner Service.

Conclusion:

2.4 Whilst the Health Board has various documents in place relating to mortality review process and interaction with the Medical Examiner Service, an overarching policy and procedure has not yet been developed as they are awaiting the production of the All-Wales policy and procedure. We have provided ***Reasonable Assurance*** for this objective.

Objective 2: Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death.

2.5 Following the passing of a patient, information including the patients notes is passed from the ward / clinician to one of the Health Board's two Bereavement Offices based in University Hospital Wales (UHW) and University Hospital Llandough (UHL).

2.6 Each Bereavement Office currently maintains their own spreadsheet to manage the process which includes inputting the patients details such as name, date of death etc. However, a development request has recently been raised which would allow the Bereavement Offices to record deaths directly into Datix rather than using separate spreadsheets.

2.7 The Bereavement Services scan the patients' medical records into the Cardiff & Vale Portal. Once the scans have been uploaded to the Cardiff & Vale Portal, an email is sent to the Medical Examiner Service confirming that the records have been uploaded and that they are ready to be accessed.

2.8 After the Medical Examiner Service has reviewed the scanned records, they discuss them by telephone or video call with the attending Health Board Doctor and the cause of death is agreed.

2.9 The attending Health Board Doctor completes and signs the Medical Certificate of Cause of Death (MCCD) which is then passed to Bereavement Services to liaise with the next of kin.

2.10 We tested 24 mortality records between June and September 2023 and found:

- In all cases, the medical records had been scanned to the Cardiff & Vale Portal and reviewing the pages indicated that the quality was good. Furthermore, we were advised that no significant feedback had been received from the Medical Examiner Service regarding the scans provided.
- The information recorded in the Bereavement Office spreadsheets was consistent with the MCCDs.
- In 18 cases, the MCCD was signed off within seven days of the date of death, in three cases this occurred within eight or nine days and in one case this occurred within twelve days. However, it should be noted that this is merely a guide to consider performance rather than a legislative requirement.
- In the remaining two cases, completion of the MCCD was delayed by the need for a Coroner's review, and emails within five and seven days of death indicated that this was in progress.

2.11 Where there are delays in signing off the MCCD, the most common cause is the availability / engagement of the Doctor. This might be reduced if the expectation regarding roles and responsibilities was set out within an overarching policy and procedure. (***Matter Arising 1 – Medium Priority***)

2.12 The proportion of Health Board bereavements which are submitted to the Medical Examiner Service has gradually increased since its introduction and since July 2023 almost 100% of deaths are now being presented.

Conclusion:

2.13 Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death. Our review of the processes did not identify any issues with the information that was sent by the Health Board. We have provided ***Reasonable Assurance*** for this objective.

Objective 3: Cases referred back to the Health Board by the Medical Examiner are subject to appropriate review in each Clinical Board.

2.14 Details regarding the cases referred back to the Health Board are recorded using Datix computer system modules which have been developed on an all Wales basis to cover the requirements of the mortality reviews and, in addition to this, the Health Board has also developed internal SharePoint records structures which it uses to supplement Datix.

2.15 Information regarding the cases and actions taken by the Health Board in response to the issues raised by the Medical Examiner is recorded in standard template boxes in both systems. Supporting documentation can be attached by the Organisational Learning Facilitator - Mortality Lead following discussion with and input from the relevant Clinical Board.

2.16 There is a backlog of cases referred back to the Health Board by the Medical Examiner Service, which reflects the introduction of the new processes. In response, the Health Board appointed a dedicated Organisational Learning Facilitator - Mortality Lead in May 2023 and is aiming to clear the backlog by March 2024. ***(Matter Arising 2 – Medium Priority)***

2.17 During the period from January to June 2023, approximately 33% and 38% of Medical Examiner reviews relating to UHW and UHL were referred back which is broadly similar to other Health Boards across Wales.

2.18 We tested a sample of twenty cases which were selected in proportion to the number of cases in each status category i.e. rejected, in progress and completed. For each case we were able to confirm that the details recorded on Datix were consistent with the Medical Examiner letter and that the Medical Examiner letter had been promptly uploaded to Datix.

2.19 Our review did however indicate that in six out of the twenty cases, the Medical Examiner letter was forwarded to the Clinical Board's Quality & Safety Lead but the outcome from this and any action taken was not provided to the Organisational Learning Facilitator - Mortality Lead. No recommendation has been made as the mortality review process has been further refined since the appointment of the Organisational Learning Facilitator - Mortality Lead and this was addressed at the time of the audit.

2.20 Approval of the responses and actions taken to date has evolved as the mortality reviews process is being developed. However, as noted under objective 4, one of the Health Board's key priorities for 2024 is to develop a Medical Examiner Scrutiny Panel which will formally review the deaths referred back to the Health Board. ***(Matter Arising 3 – Medium Priority)***

2.21 The Health Board is not required to respond to the Medical Examiner letters. Responses are purely internal within the Health Board.

Conclusion:

2.22 The Organisational Learning Facilitator - Mortality Lead considers and reviews cases received from the Medical Examiner Service and liaises with the Clinical Boards regarding responses. Currently, the Health Board are undertaking a number of ongoing reviews to clear the backlog that have been received from the Medical Examiner. We have provided ***Reasonable Assurance*** for this objective.

Objective 4: Adequate review and reporting of the mortality review process is undertaken within Clinical Boards, with dissemination across Directorates and Clinical Boards and escalation to Health Board Committees to ensure lessons are learned.

2.23 Clinical Boards are expected to consider mortality at their QSE meetings, although there is some variation in how this is done at present and so the Health Board is looking to review and standardise their QSE agendas during 2024.

2.24 The Health Board has in place a Learning from Mortality Group which has an up-to-date terms of reference in place, which includes implementing the All Wales Learning from Mortality Review Model Framework and supporting learning and improvement relating to mortality.

2.25 The Group meets bi-monthly and is attended by the Lead Medical Examiner for Wales and a cross section of relevant staff from across the Health Board including Patient Safety, Organisational Learning, Medical Records and the various Clinical Boards. The group reports into the Clinical Safety Group.

2.26 The Group's activities during 2023 have included:

- Investigation of the reasons for delays in issuing Medical Certificates of Cause of Death (MCCDs);
- Development of a dashboard which can be accessed live by the Clinical Boards to aid learning, identify emerging themes and feed into reporting at Quality and Safety meetings; and
- Receiving updates and feedback from the Lead Medical Examiner for Wales.

2.27 Regular high level updates regarding deaths have been provided to the Quality, Safety and Experience Committee during 2023 and on the 28 November 2023 a detailed deep dive mortality review was presented as stated above which included:

- The background and an overview of the Health Board's arrangements and data summarising mortality numbers;
- Detailed reviews for Children & Women, Medicine, Mental Health, Specialist Services and Surgery Clinical Boards;
- Information regarding the Medical Examiner Service, Learning from Mortality Group and Coroner cases; and
- Key points to note including:
  - Close to 100% of inpatient deaths are now receiving independent scrutiny by the Medical Examiner Service and this will be extended to community deaths in 2024; and
  - The referral rate from the Medical Examiner Service back to the Health Board is in line with national rates as are referrals to HM Coroner.

2.28 The Health Board has made good progress in shaping its mortality review processes and interaction with the Medical Examiner Service. However, further work is

required to ensure that the processes are fully developed to enable effective and consistent learning. From our review of the Learning from Mortality Group minutes and a deep dive paper presented to the Quality, Safety and Experience Committee on the 28 November 2023, it is evident that the Health Board recognises this and has identified its key priorities for 2024, which it will need to ensure are effectively delivered. ***(Matter Arising 3 – Medium Priority)***

Conclusion:

2.29 There is a Learning from Mortality Group in place which is developing the Health Board's mortality review processes to enable lessons to be learned and appropriate updates are being provided to the Quality, Safety and Experience Committee. However, we note that the process is ongoing and that further work, including in relation to Clinical Boards, is planned for 2024. We have provided ***Reasonable Assurance*** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies and procedures (Design)	**Impact**
There is an All-Wales Learning from Mortality Review Model Framework in the process of being developed which describes the role of the Medical Examiners and the Health Board and how it interacts with other processes such as Putting Things Right. Subsequently, the Health Board does not have an overarching policy and procedure in place which details the mortality review process. The Health Board's intranet includes a page which provides information regarding the Medical Examiner Service and has a link to the Medical Examiner Service's own web pages. However, further changes to the Medical Examiner Service in relation to the Coroner Service are due to occur going forward. Flowcharts have been developed for specific areas of the mortality process and the Bereavement Services booklet for next of kin explains the Medical Examiner Service arrangements.	Correct procedures may not be followed in connection with mortality reviews and interaction with the Medical Examiner Service.

Recommendations		**Priority**
1.1	The Health Board should develop an overarching policy and procedure following completion and approval of the All-Wales Learning for Mortality Review Model Framework which sets out the respective roles and responsibilities and the procedures which should be followed.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Development of a learning from mortality framework	Spring 2025	Aled Roberts, AMD patient safety Alex Scott, Assistant Director of Quality and Patient Safety

Matter Arising 2: Review of cases not up to date (Operation)	**Impact**
Cases are referred back to the Health Board when the Medical Examiner considers that the patient records indicate that there is an issue which requires consideration. The first case referred back to the Health Board was received in September 2021 and since then approximately 1100 cases in total have been referred back. Approximately 75% of all cases referred back have undergone internal review and been closed, 22% have open internal reviews in progress and 3% were rejected. We reviewed the number of referred cases by the Medical Examiner that have now been closed within the Health Board and identified: • 100% of cases have been closed relating to 2021, • 90% of cases closed relating to 2022 and • 61% of closed cases relating to 2023. We have been informed that the Health Board's aim is to clear the backlog of open cases by March 2024.	Patient deaths due to lessons not being learnt and action not being taken on a timely basis.

Recommendations		**Priority**
2.1	The Health Board should attempt to: • Clear the backlog of open cases as soon as possible, ideally by its intended deadline of March 2024. • Ensure that new cases are reviewed and responded to on a timely basis.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Delivery of C&V scrutiny panel to review all cases referred from ME Development of reporting measures to ensure timely internal responses to ME referrals	June 2024 January 2025	Aled Roberts, AMD patient safety

Matter Arising 3: Key priorities for the Learning from Mortality Group in 2024 (Operation)	**Impact**
From our review of the Learning from Mortality Group minutes, and a deep dive paper presented to the Quality, Safety and Experience Committee on the 28 November 2023, its key priorities for 2024 for further improving the mortality review processes included: 1. Development of a Health Board Medical Examiner Scrutiny Panel which will review deaths sent to the Health Board by the Medical Examiner Service; 2. Setting up a Mortality and Morbidity (M&M) Group which will review Clinical Board processes in place and seek to develop a standard approach across the Health Board; 3. Making information from the Medical Examiner process available to Clinical Boards and Directorates through development of regular reports and the interactive dashboard; and 4. Providing education and resources to support staff in the death certification process.	Lessons from mortalities may not be adequately learned.

Recommendations		**Priority**
3.1	Ensure that the key priorities for 2024 are effectively implemented.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	1 – Delivery of C&V scrutiny panel to review all cases referred from ME.	June 2024	Aled Roberts, AMD patient safety
	2 – Setting up a Mortality and Morbidity (M&M) Group is in progress.	September 2024	Alex Scott, Assistant Director of Quality and Patient Safety
	3 – Making information from the Medical Examiner process available is in progress in conjunction with delivery of ME scrutiny panel.	June 2024	Matt Macarthy, Interim Head of Safety, Quality and Organisational Learning

	4 – Bereavement processes T&F group in progress.	Autumn 2024	Nic Denny, Organisational Learning Facilitator – Mortality Lead Angela Hughes, Assistant Director of Patient Experience

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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