

# Mortality Review Processes at SWBH



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# Aims of the session



- To provide an overview of the review of mortality data in the Trust
- To indicate the role of the Clinical Effectiveness Department in the process
- To share some of our learning about the review of mortality data

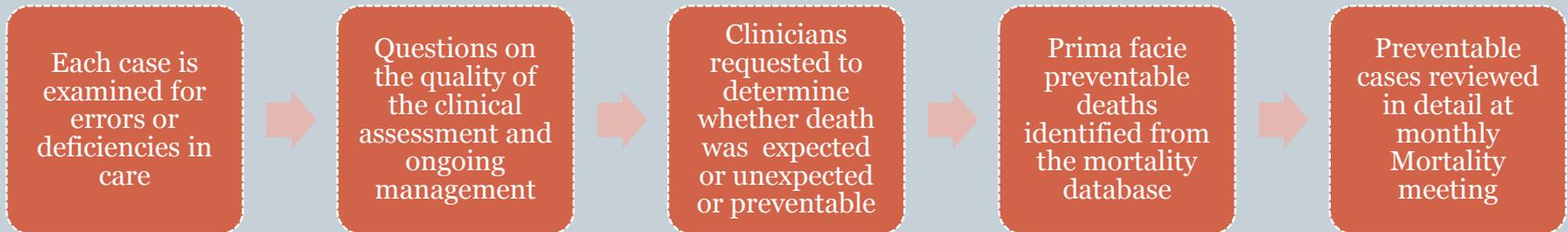
# Supporting Structure



# Local review of deaths in hospital Mortality Review System



# Mortality Review System



# Mortality Review System



Incident form completed if  
not already done  
Secondary review  
commissioned



Checking 'Duty of Candour'  
requirements complied with.



Now preventable deaths to be  
reported to the Coroner

# Process for Mortality Indicators



- Interrogation of CHKS for data on Risk Adjusted Mortality Index (RAMI).
- Interrogation of HED for data on Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital Mortality Indicator (SHMI).
- Values are examined for the Trust, and broken down by Site, Specialty Weekend, Weekday, Low risk diagnosis groups.
- Confidence intervals are applied to values and further investigations commissioned through the Mortality & Quality Alerts Committee as required.

# Outcomes



- Local data from the review process has helped in providing responses to Mortality Outlier Alerts. They give some indication of the quality of care received during the admission
- We have identified trends before outlier alerts have been generated.
- Themes identified and initiatives launched in response e.g. management of sepsis.
- Quarterly newsletter produced ('Death Matters') highlighting themes.
- Monthly email communications - summaries highlighting the learning.

# Our Learning



- Mortality indicators provide an indication of where a problem might exist and this has to be triangulated with other local intelligence.
- Highlighted the need for improved clinical coding and about being clear on the primary diagnosis in the first episode.
- Feeding back on outcomes is essential to maintain engagement.
- Local CQUIN has been critical to ensuring that 90%+ in-hospital deaths are reviewed.
- We have needed dedicated resources to drive processes forward.