MORTALITY REVIEW POLICY

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Policy Owner	Medical Director		
Author	Associate Director of Patient Safety & Quality		
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Staff/Groups Consulted	Associate Director, Patient Safety and Quality Clinical Directors Clinical Director, Patient Safety Legal Services Manager Clinical Outcomes Lead Non-executive Directors Medical Director		
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Policy Audited			
Equality Impact Assessment Completed	Yes		

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1. BACKGROUND

1.1 Learning From Deaths. The Care Quality Commission's recent review into Southern Health NHS Foundation Trust, Learning, candour and accountability, emphasised the importance of providers putting in place robust arrangements to identify, report, review, investigate and learn from deaths of patients under their care. NHS Trusts and Foundation Trusts are specifically obliged to comply with the detailed guidance which the National Quality Board has subsequently published (National Guidance on Learning from Deaths, available at https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/).

1.2 Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures combined with a focus on mortality rates and patient safety ratings for NHS Trusts. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe in line with the National Guidance on Learning from Deaths (March, 2017).

1.3 Effective clinical audit and review processes incorporating analysis of mortality and morbidity contribute to improved patient safety. The specialty Mortality & Morbidity (M&M) meetings, established to review deaths as part of professional learning, also have the potential to help provide assurance that patients are not dying as a consequence of unsafe clinical practices.

1.4 Concentrating attention on the factors that cause deaths will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient.

1.5 Retrospective case note reviews help to identify examples where processes can be improved and gain an understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care.

1.6 A formalised process will also address the Care Quality Commission's publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, 'Learning, candour and accountability' which builds on the need to maximise learning from deaths.

1.7 This standardised trust-wide process integrating mortality reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes.

2. PURPOSE

2.1 The policy has been written to provide guidance for all staff involved in mortality reviews including clinicians, clinical coding, governance, performance analysts, end-

of-life and palliative care, and clinical audit and effectiveness staff.

2.2 The aim of the mortality review process is to:

- Identify and minimise 'preventable' deaths in all Trust hospital sites
- Review the quality of end of life care
- Ensure that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Identify and minimise avoidable admissions or late presentation
- Enable informed reporting with a transparent methodology
- Promote organisational learning and improvement

3. DEFINITIONS

3.1 Mortality rate

The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

3.2 Mortality review process

A structured methodology for retrospective case note review following a patient's death to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

3.3 CRAB

Copeland's Risk Adjusted Barometer - a system for assessing, monitoring and improving the quality of care, through predicting the clinical risk for individual patients with risk adjustment for complications which enables clinicians and the organisation to understand morbidity and avoidable harm.

3.4 Serious Incidents

Adverse events that can result in harm to the patient including severe harm and death that require investigation using Level 1 (Concise) and Level 2 (Comprehensive) Root Cause Analysis and associated methodologies. In line with national guidance and local policies.

3.5 Intrauterine Deaths, Stillbirths, Neonatal and Maternal Deaths

Deaths that require investigation in accordance with national guidance using predefined methodologies, perinatal mortality review tools and reporting systems such as MBRACE and Child Death Review Panels.

3.6 Learning Disability Mortality Review Programme (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere

4.   SCOPE

4.1   This Policy relates to the following staff groups who may be involved in the mortality review process:

- Medical Staff
- Senior Nursing Staff
- Clinical Coding Staff
- Clinical Audit & Effectiveness Staff
- Performance Analysts
- Quality Improvement Staff
- Governance Staff

4.2   The mortality review process is applicable to:

- All in-hospital deaths in all specialties
- Diagnosis groups identified by CQC/CRAB
- Diagnosis groups identified by the Mortality Review Committee

4.3   The mortality review process forms one aspect of the Trust's quality improvement work. The aim is that all in-hospital deaths will be reviewed using the agreed Structured Judgement Review Tool or associated methodologies (RCA, Perinatal Mortality Review Tool)

4.4   The Head of Maternity will ensure all mortality reviews for all Intrauterine Deaths, Stillbirths, Neonatal and Maternal Deaths are completed and are aligned to the reporting processes of this policy.

4.5   All deaths of a patient with a Learning Disability will be logged with the National LeDeR notification system by the Clinical Governance team. The LeDeR programme provides an opportunity for peer review of all Learning Disability deaths. The learning from these is co-ordinated and shared via the LeDeR Steering Group, with representatives on the Steering Group providing shared learning to the Integrated Learning Forum.

All deaths of inpatients with a Learning Disability will be subject to immediate review to identify any immediate actions required.

4.6   The Child Death Overview Panel reviews all child deaths. Notification of a child death to the Local Safeguarding Children Board is made at the time of any agency becoming aware of:
• a child death occurring in Somerset
• a death of a normally resident Somerset child occurring elsewhere

Notification is made using the Form A – Notification of a Child Death and sending this to the Child Death Administrator from the Somerset Safeguarding Children Board who can

be contacted on 01823 357178. This is usually undertaken by the Paediatrician managing the case.

5. ROLES AND RESPONSIBILITIES

5.1 The overall responsibility for the mortality review process sits with the Medical Director who will report outcomes and findings to the Clinical Outcomes and Governance Assurance Committees and to the Trust Board.

5.2 Mortality Review Group

The Mortality Review Group will be responsible for:
- Providing assurance to the Governance Assurance Committee and Trust Board on patient mortality based on review of care received by those who die
- Agreeing and approving the mortality review proforma
- Reviewing M&M outcomes, audit data and action plans
- Identifying areas of high risk and agreeing and monitoring improvement plans
- Ensuring that feedback and learning points are shared with the divisions and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate.

5.3 Medical Director

The Medical Director will be responsible for:
- Overall oversight and regular review of the mortality review process
- Identifying the relevant Clinical Director to ensure completion of the individual mortality review or mortality alert reviews as required
- Carrying out notes reviews with clinical coding where coding issues are identified

5.4 Clinical Directors and Consultant Audit Leads

The Clinical Directors and Consultant Audit Leads will be responsible for:
- Ensuring all deaths are reviewed using the mortality review proforma available on the Trust intranet
- Identifying clinicians to complete the mortality reviews and recording findings on the mortality review proformas
- Ensuring that patients' families and carers are given an opportunity to be engaged with the review process, including providing feedback on the outcomes of the review as appropriate. (Advice on the process to follow is available in the Duty of Candour Policy or via the Clinical Governance Team)

- Ensuring that all pertinent cases and findings from mortality reviews are presented by the appropriate clinical leads at specialty M&M meetings and to the Clinical Outcomes Committee.
- Ensuring that outcomes and learning from M&M meetings are recorded and action plans for improvement are developed where required
- Ensuring that findings are evaluated and reported to specialty and divisional governance meetings to promote learning
- Overseeing progress on the implementation of action plans and keeping

governance informed
- Feeding back findings from mortality reviews and M&M meetings to the Mortality Review Group

5.5 Senior Nursing Staff

Senior Nursing staff will be responsible for:
- Participating in mortality reviews wherever possible, either in person or by nominated staff being available for advice on nursing issue

5.6 Clinical Coding Staff

Clinical Coding staff will be responsible for:
- Participating in mortality reviews where coding issues have been identified
- Routinely reviewing alerting diagnosis groups in CRAB from patient lists provided by the Performance Team each month

5.7 Clinical Governance Team / Information Department

The Clinical Governance team will be responsible for:
- Sending a list of Trust deaths to the Medical Director, Clinical Directors and Consultant Audit Leads which will include inpatient information
- Requesting the patient notes and supplying the relevant patient details, including incident and post mortem information, to the clinicians nominated for individual reviews or where a diagnosis group has been highlighted by the CQC or the Mortality Review Group
- Providing patient lists to the Clinical Coding Team each month where diagnosis groups are alerting
- Producing reports based on information recorded
- Maintaining a library of completed review forms and feeding back the reports and outcomes to the clinical leads for each area
- Analysis of the database to identify themes and trends
- Recording special reviews
- Ensuring learning outcomes and action points are included in the specialty audit programmes as appropriate
- Recording known incidents, inquests and post mortems on the list of Trust deaths
- Overseeing the process of mortality alert reviews and production of associated reports
- Monitor identified learning outcomes and associated action plans
- Support the review process with any identified duty of candour requirements

6. CLINICAL CODING

6.1 Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a number of reasons, not least that it constitutes the raw data upon which decisions are made about the Trust's income.

6.2 Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or

hinder that process.

6.3 This is supported as part of the mortality review process through clinical coding staff involvement in the individual reviews and mortality alert reviews, guidance for clinical staff on the Trust intranet, and other clinical coding training sessions.

7. PROCESS FOR CARRYING OUT MORTALITY REVIEWS

7.1 The process for the conduct of mortality reviews is outlined in the flow chart at Appendix A. Key steps are described below:

7.2 Notification of patient deaths

- Patient deaths are notified through the Bereavement Office, including post-mortem information where known
- Deceased notes are forwarded to the Clinical Governance Team for categorising and to be logged on the mortality review register
- Checks are made by the Governance Team against any investigations commissioned and these are noted.
- Checks are made by the Governance Team against the end of life pathway and these are noted.
- Where concerns have been raised about a patient's care and treatment, i.e. through an incident report or complaint, the mortality review should be carried out and used to inform any formal serious incident investigation.
- If there is an identified duty of candour issue the mortality reviewers should act according to the guidance in the relevant Trust policy

7.3 Mortality reviews

- The Clinical Governance Team identify consultant team responsible for competing the review and forward patient notes to responsible team
- The SJRT is completed on the Trust intranet
- The reviewer(s) should ensure that the patients' family and/or carers have been contacted and given an opportunity to be engaged in the review. The Duty of Candour Policy contains advice on how to approach this
- The reviews should be completed by the nominated reviewers
- The findings of the mortality reviews should be recorded on the National Mortality Case Record Review on the Trust intranet

7.4 Clinical coding

- Where clinical coding issues have been identified the notes should be sent to the Medical Director.
- The Medical Director and Clinical Coding will meet to review the notes and coding queries.
- Findings from this review should be fed back to the clinicians and clinical coders to promote learning and improvement in documentation and coding.

7.5 Outcomes

- Where concerns have been identified but no incident has previously been reported, the appropriate Clinical Director should be informed by the nominated reviewer and an incident report with brief details should be raised on Safeguard to trigger further investigation.
- In addition, if there are found to be concerns about the standard of care then the case should be reviewed in-depth by a multi-disciplinary team at the regular departmental M&M meetings.
- Completed mortality reviews should be evaluated and the findings reported to the specialty M&M meetings and divisional governance day.
- Discussions, outcomes and learning from the M&M meetings, including conclusions about outstanding care and sub-optimal care, should be formally recorded and reported to the Mortality Review Committee.
- Mortality reviews and in-depth reviews from M&M meetings should be used to inform any subsequent investigations, for example SEA, SIRI, complaint or legal claim.
- Outcomes from the mortality review should be fed-back to the patient's family and/or carers if that is their wish. Advice on the process to follow is available in the Duty of Candour Policy or via the Governance Team.

8. PROCESS FOR RESPONDING TO A MORTALITY ALERT

8.1 If there are concerns about mortality in any particular patient group, (e.g. CQC alert, CRAB alert, elevated SMR for a particular diagnostic group, or global high weekend mortality) it will be necessary to undertake an in-depth case note review.

8.2 Alert received

- The Clinical Governance Team should inform the Medical Director, addition, the CRAB alerts should be communicated with the Care Quality Commission (CQC) in a timely fashion once the results of the initial clinical coding review are known.

8.3 Clinical coding review

- The correct cohort of patients should be identified by the Performance Analyst, dependent on the source of the concern, and a list sent to Clinical Coding initially to check coding accuracy.

- If the result of the clinical coding audit is greater than or equal to 75% accuracy, this will trigger a full case note review.

8.4 Approval of full case note review

- The need for a full case note review should be approved by the Mortality Review Committee at their next meeting. The Committee should also identify appropriate consultant(s) to undertake the review and the cohort of patients whose care and treatment require review.
- The agreed cohort patient list should be collated by the Performance Analyst

and sent to Clinical Audit & Effectiveness.

- Once the full case note review has been agreed, the CQC should be informed by Governance that a review is being carried out due to a diagnosis group flagging.

8.5 Case note reviews

- The Performance Analyst should request the relevant patient notes and ensure that the appropriate details including incidents and post mortem information are available to the case note reviewers.
- An appropriate multi-disciplinary group should carry out the review, together with a lead with overall responsibility for the review and writing up the result.

- Assessment of clinical coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care.
- A review of the case notes for a reasonable consecutive sample of the patients who died (normally 30-40) should be undertaken in order to establish whether the clinical care the patients received was appropriate.
- The care for each case should be recorded on the Trust mortality review audit proforma and sent to the Clinical Audit & Effectiveness Team to record on the Keypoint database.

8.6 Reporting findings

- A report should be constructed demonstrating methodology, findings, learning and recommendations.
- Reports from Performance (superspells and demographics of the whole cohort) and Clinical Audit (findings relating to the reviewed cases) should be produced to help populate the draft report with the relevant data.
- The identified lead for the review should add appropriate narrative and finalise the report, liaising with the Medical Director and Governance for action planning.
- The identified lead should present the draft report and findings to the Mortality Review Committee for approval.

9. MORTALITY & MORBIDITY MEETINGS (M&M)

9.1 Participation in mortality and morbidity (M&M) meetings should be considered a core activity for all clinicians. Whilst it is recognised that different departments will have different requirements and aims in relation to M&M meetings, the main principles are that they should be a forum for discussion of deaths and other clinical adverse events.

9.2 The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. The M&M meeting has a central function in supporting services to achieve and maintain high standards of care.

9.3 For further information on the organisation and conduct of M&M meetings please see the associated M&M meetings standard operating procedure.

10.   FEEDBACK TO THE FRONTLINE

10.1   It is recognised that clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is therefore essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign.

10.2   Dashboards showing outcomes at individual / team / ward / department level will be developed and form part of the mortality review reports to divisions and the Mortality Review Committee.

11.   REFERENCES

- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of
- Surgeons (2015)
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England
- Higginson J, Walters R, Fulop N, BMJ Qual Saf (2012), Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?
- Learning Disabilities Mortality Review (LeDeR) Programme (2017)
- National Guidance on Learning from Deaths, A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, 2017)

12.   ASSOCIATED DOCUMENTATION

Yeovil District Hospital Trust Policies for:

- Incident Reporting and Investigation
- Complaints and Concerns
- End of Life

Learning from Deaths in the NHS

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All deaths  →  Bereavement Register

Bereavement Register  →  Coroners
Bereavement Register  →  Clinical Governance (Decision re: RCA, EoL audit, LD, Complaint, CRR)

Clinical Governance  →  Quarterly Reporting from April 2017

Quarterly Reporting from April 2017  →
    Total number of deaths in the acute Trust (including ED deaths)
    Total number of deaths subject to a case review
    Total number of deaths investigated under the serious incidents framework
    Number of deaths thought more likely than not to be due to problems with care
        - Themes and issues identified through review and investigations
        - Actions taken as a result

Clinical Governance  →  Case Record Reviews
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Case Record Reviews →

| All deaths carers / staff significant concerns re: care | All Learning Disability Deaths (LeDeR) | Any deaths having elevated mortality alerts e.g. SHMI CRAB | All Unexpected Deaths incl. SIs e.g. elective procedures, adverse events, stillbirths | All deaths of patients with severe mental illness | Deaths where learning will inform QI work of the Trust E.g. Sepsis, EOLC | Further sample of deaths E.G. selection of deaths from each weekday |

Yeovil Hospital Healthcare

Appendix 3 – Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Mortality Review Process**

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	-	
6.	What alternatives are there to achieving the policy/guidance without the impact?	-	
7.	Can we reduce the impact by taking different action?	-	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Name: Jo Howarth   **Date:** 28/07/2017