Mortality Review Policy

1. Indications

1.1 Background

Concern about patient safety and scrutiny of mortality rates has intensified since a number of investigations of NHS hospital failures have published their findings over the last few years. Most recently the findings of a Care Quality Commission (CQC) report 'learning, candour and accountability' found that learning from deaths was not being given sufficient priority in some organisations and opportunities for improvements were being missed. The report made it clear that more could be done to engage families and carers and to recognise their insights as a source of learning.

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

The National Quality Board (2017) published national guidance on learning from deaths which sets out a framework for Trusts on identifying, reporting, investigating and learning from deaths in care. Boards need to be assured that deaths are reviewed and changes are made in response to learning to improve pathways of care. Trusts are required to collect and publish quarterly reports with specified information on deaths and demonstrate learning. The report must be presented to a public Board meeting.

1.2 Aim/purpose

This policy confirms the process of identifying, reporting, investigating and learning from deaths in care to ensure a consistent and co-ordinated approach of the review of deaths in hospital.

The aim is to identify areas of practice, both specific to individual cases and learning from themes, to improve and minimise avoidable deaths and review the quality of care. The process should also improve the experience of families and carers through better opportunities for involvement in investigations and reviews. Areas of good practice should also be identified to learn from excellence.

1.3 Patient group

The mortality review process is applicable to:

- All in-hospital deaths in all specialties including patients who die in the Hospice.

As a minimum the following deaths must be reviewed:

- Elective admissions that result in death
- Unexpected deaths
- Patients with learning disabilities aged 4 years and older (these deaths must also be reported to the Learning Disabilities Mortality Review programme (LeDeR).
- Patients with severe mental health illness and those detained under the Mental Health Act.
- Stillbirths and neonatal deaths
- All child deaths (these deaths must also be reviewed by the Wiltshire and Swindon Child Death Overview Panel).
- A maternal death
- Deaths where a bereaved family and carers or staff have raised a significant concern about the quality of care.
- Diagnosis or procedure groups that trigger a CUSUM alert raised by Dr Foster Healthcare Intelligence dashboard or the Care Quality Commission and deaths in low risk groups.
- Deaths related to a Coroner's inquest, adverse events or complaints.
- Deaths where learning will inform existing or planned improvement work.
- A further sample of randomly selected deaths that do not fit into the above groups where learning and improvement is needed such as from national or local audits.

1.4 Exceptions

- Out of hospital cardiac arrests

1.5 Options

- Deaths of patients with learning disabilities standard operating procedure – appendix 4
- Deaths of patients with severe mental illness or detained under the Mental Health Act standard operating procedure – appendix 5
- Deaths of children and young people – appendix 6
- Stillbirths and neonatal death standard operating procedure – appendix 7
- Action in the event of a maternal death – appendix 8

1.6 Scope

This policy applies to the following groups of staff who may be involved in the mortality review process:

- Medical staff
- Senior nursing and midwifery staff
- Clinical coding staff
- Information analysts
- Bereavement suite staff
- Risk management
- Clinical Effectiveness

- Patient experience staff

1.7 Roles and responsibilities

1.7.1 Board leadership

The overall responsibility for the mortality review process and learning from deaths rests with the Medical Director who will report outcomes and findings to the Trust Board.

A non-executive director takes responsibility for the oversight of progress in the review process, learning from problems in care and improvement, by constructive challenge and support of performance, and that the information published is a fair and accurate reflection of achievements and challenges.

1.7.2 Mortality Surveillance Group

The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for:

Working towards the identification of all avoidable in-hospital mortality and commissioning work to improve patient processes, pathways and outcomes. The group is responsible for publishing the Trust's annual avoidable mortality rate. The terms of reference require the group to:

1. Review the mortality rates of the Trust (HSMR, SHMI and SHMI adjusted for palliative care).
2. Track deaths in the highest risk groups such as those with sepsis, pneumonia, stroke, myocardial infarction, heart failure, acute kidney injury and fractured hip.
3. Track deaths of patients who die within 48 hours of admission and work with GPs and commissioners to investigate the reasons for admission and show evidence of improvement.
4. Report the 3 biggest causes of deaths and current mortality rates.
5. Review the learning points of any Serious Incident Inquiries and clinical reviews arising from a patient's death and report them to the Mortality Surveillance Group.
6. Consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation using Dr Foster's Healthcare Intelligence dashboard.
7. Investigate any 'red flag' diagnosis or procedure groups, CUSUM alerts and any alerts received from the Care Quality Commission.
8. Ensure mortality information linked to consultant appraisal is accurate, in context and creates a culture of clinical excellence.
9. Commission clinical coding audits and clinical audits and receive reports on implementation and improvement.
10. Assign clinical leads to address raised mortality in particular areas or specialties and for the implementation of evidence based interventions such as care bundles. The MSG will receive regular reports on implementation and the impact of the intervention on hospital mortality.
11. Work collaboratively with the Resuscitation Committee and End of Life Care Steering Group to review and monitor compliance of key policies such as DNAR and the End of Life Care Strategy.
12. Work collaboratively with the Patient Safety Programme and receive quarterly reports and report mortality to the Patient Safety Steering group.
13. Annually receive all child deaths reports.
14. Review deaths of patients with learning disabilities and a serious mental health diagnosis and link with the Learning Disability Working group.
15. Communicate learning from mortality alerts across the Trust through relevant channels such as newsletters, at Clinical Governance half days and executive performance meetings.

1.7.3 Clinical Directors

The clinical directors are responsible for:

- Identifying clinicians to lead the mortality review process in each specialty and record findings on the Trust's electronic mortality reporting tool.
- Ensuring specialties review and record the outcome of deaths in the above patient groups (section 1.3).
- Ensuring each specialty hold regular mortality and morbidity meetings and outcomes and learning are recorded along with action plans for improvement. Learning is shared with the whole team and at governance meetings.
- Ensuring that patients families and carers are given an opportunity to engage with the review process and are given feedback on the outcomes of a review.
- Reporting progress with the mortality review process, learning and improvement at the Executive Performance meetings and Mortality Surveillance Group.

1.7.4 Medical staff

All medical staff are responsible for:

- Screening deaths for the quality of care and avoidability of death.
- Leading mortality reviews within their service ensuring relevant cases are presented at mortality and morbidity meetings, outcomes recorded and actions for improvement are implemented where required.
- Overseeing progress of the action plan and reporting to the Clinical Director.
- Participating in mortality reviews and providing advice on medical issues.
- Ensuring that families and carers are given an opportunity to engage with the review process including providing feedback on the outcomes of the review.
- Complying with the statutory duty of candour.
- Learning from reviews and supporting implementation of improvement actions
- Education of junior doctors in the mortality process and learning.

1.7.5 Senior nursing and midwifery staff

Senior nursing and midwifery staff are responsible for:

- Participating in mortality reviews and providing advice on nursing and midwifery issues.
- Involving and listening to families and carers about any concerns in care and providing feedback to the family, carer or Directorate management team or customer care team.

- Learning from reviews and supporting implementation of improvement actions.

1.7.6 Clinical coding staff

Clinical coding staff are responsible for:

- Participating in mortality reviews by providing the case notes and ensuring deaths are coded accurately, particularly palliative care codes and co-morbidity codes.
- As a minimum an annual audit of mortality coding is undertaken to provide assurance of data quality.
- Providing clinicians with training on the importance of the way they record clinical findings and opinions.

1.7.7 Information analyst staff

Information analysts are responsible for:

- Providing access to the Hospital Application Log in service to enable nominated clinicians to search for patient deaths by date, specialty, admission source, primary and secondary diagnosis.
- Providing access to Dr Foster's Healthcare Intelligence dashboard to nominated clinicians.
- Populating the Trust wide score card with mortality information.

1.7.8 Bereavement suite staff

Bereavement suite staff are responsible for:

- Reviewing the daily list of deaths and ensuring medical certificates are completed accurately.
- Supporting medical staff with the medical certification process, discussion with the pathologist and/or the coroner's officer if needed.
- Signposting junior medical staff to senior medical opinion when reviewing a death and ensuring the doctor completes a mortality screening form (see appendix 1).
- Entering the cause of death from the medical certificate in the patient record on Lorenzo or 'referred to the coroner' if the medical certificate cannot be issued.
- Asking relatives and carers whether they had any concerns about the care of the patient and where needed arranging for them to be put in contact with the responsible team.
- Offering relatives and carers a bereavement survey to enable them to comment on the care provided and any concerns they may have.
- Arranging an appointment for the relatives to collect the medical certificate and signposting them to the Registrar of Births and Deaths service available in the hospital.
- Notifying the GP and any other organisation who was involved with the care of the patient.

1.7.9 Risk management team

The risk management team are responsible for:

- Working with clinicians to identify whether an incident involving a death meets the national serious incident framework criteria and decisions are appropriately documented.
- Identifying a lead to ensure the statutory duty of candour requirements are complied with.
- Working with the Directorate Management Team to ensure there is support available for families and carers.
- In conjunction with the Directorate Management Team identify relevant evidence and panel to review the case.
- Being a link with other organisations and external stakeholders to obtain additional information relevant to the investigation.
- Collating evidence to ensure that recommendations are completed and the learning shared.

1.7.10 Clinical effectiveness

The Head of Clinical Effectiveness is responsible for:

- Supporting the mortality review process and the Mortality Surveillance Group.
- Ensuring learning outcomes and action points are included in the Directorate audit plan as needed.
- A member of the clinical audit team enters the information from the mortality screening form on the Trust's electronic mortality review tool.
- A member of the clinical audit team presents the bereavement survey data to the clinical lead for analysis.

1.7.11 Patient experience

The Head of Customer care is responsible for:

- Ensuring that any death that results in a complaint or a concern is investigated and families and carers are given an opportunity to be engaged with the review process including being provided with feedback on the outcome of the review.
- A death that results in a complaint or a concern must be reviewed by a speciality M&M meeting and the outcome reported to the Directorate Management Team

1.7.12 West of England Academic Health Science Network (AHSN)

The AHSN supports implementation of the national guidance at local level:

- The Medical Director and Head of Clinical Effectiveness are the link with the AHSN and report progress to the Mortality Surveillance Group.
- Providing a forum for learning and improvement.
- Providing knowledge and skills training to local mortality leads.

2. Clinical Management

2.1 Mortality review process

The process for the conduct of mortality reviews is outlined in the flow chart in appendix 3.

2.2 Notification of deaths

- Bereavement Suite staff will ensure that the junior doctor completes a mortality screening form and sends it to the Clinical Effectiveness team for entry into the electronic mortality review tool.

2.3 Mortality reviews

2.3.1 Screening/1st review

- The doctor completing the mortality screening form should discuss the case with a consultant or senior doctor and record if there were any concerns about the quality of care or avoidability of death.

2.3.2 2nd review

- A 2nd review of the case should be undertaken by the specialty mortality and morbidity meeting and a member of the Mortality Surveillance group of all of the following groups:
    - elective admissions resulting in death
    - unexpected deaths
    - patients with learning disabilities
    - patients with serious mental illness and/or detained under the Mental Health Act
    - child death up to 18 years old including stillbirth and neonatal deaths.
    - maternal death
    - If the initial screen was not discussed with a consultant/senior doctor
    - If the family or carers have any concerns about the patients care either verbally, from a written complaint or concern or from the bereavement survey.
    - If the quality of care was rated as very poor, poor or adequate care which may have contributed to the death.
    - If the death was possibly, probably or there was strong or definite evidence of avoidability.
    - The Mortality Surveillance Group will undertake a review of a random sample of all deaths.
- The findings of the mortality review should be recorded on the Trust's electronic mortality review tool available on the intranet.
- As part of the process reviewers are asked to make a judgement on whether there was any evidence that the death could have been avoided using the Hogan study scale and identify any learning. (1. No evidence death was avoidable 2. Slight evidence the death was avoidable 3. Possibly avoidable but not very likely, less than 50/50 4. Probably avoidable, more than 50/50 5. Strong evidence of avoidability. 6. Definitely avoidable).
- As part of the process reviewers are asked to make a judgement on the quality of care and identify any learning.
- Where concerns have been identified or the quality of care is rated as 1 or 2 (poor or very poor care) or there was strong or definite evidence the death was avoidable, but no incident has previously been reported, the Head of Risk should be informed and an incident report completed on DATIX to trigger further investigation. Please note, the mortality screening process does not replace incident reporting.
- Discussions, outcomes and learning from the mortality and morbidity meetings, including conclusions about outstanding care and sub-optimal care should be formally recorded and reported to the Mortality Surveillance Group and Directorate Management Team.

2.4 Mortality and morbidity meetings

Mortality and morbidity meetings contribute to improved patient safety and are a requirement of all specialties.

The aim is to review all cases of patients who have died. However, it is recognised that in specialties with a higher number of deaths it may not be possible to review all of them, but instead, a random selection should be reviewed. Any patient in the above group in section 2.3 must be reviewed and those who suffered a complication or adverse incident or outcome in a structured and systematic way for the purposes of:

- Discussing clinical decision making, system and process of care failures.
- Identifying opportunities to improve patient safety and the quality of care.
- Learning and improvement through actions and follow up of actions taken to prevent similar outcomes or adverse incidents.
- Reporting of meeting outcomes and assurance to the Board.

Mortality and morbidity meeting standards/guidelines and a meeting report template are available at the following link http://intranet/website/staff/formstemplates/mortalityreporting/home.asp and as appendix 11 & appendix 12.

2.5 Responding to a mortality alert process

Mortality in a diagnostic or procedure group may trigger a CUSUM alert if more deaths are observed compared to the number expected (e.g Dr Foster Healthcare intelligence CUSUM alerts, CQC alert, weekend mortality or deaths in low risk groups). When this is the case it will be necessary to undertake a case notes review of patients in that group for the time period of the alert.

Alert received:

- Dr Foster's Healthcare Intelligence dashboard should be reviewed monthly to identify CUSUM alerts, deaths in low risk groups and deaths by day of admission and reported to the Mortality Surveillance Group. The chair will nominate a reviewer for each alert and expect them to review the relevant cases and report their findings, learning and improvement actions required at a subsequent meeting.
- The Medical Director notifies the Mortality Surveillance Group of any CQC alerts, nominates a clinician to undertake the review and write a report of their findings, learning and improvement actions required.

Clinical coding review:

- The patient cohort for each alert should be identified and a list sent to the clinical coding team to check the coding accuracy.
- The outcome of the coding review should be reported to the nominated clinician undertaking the review.

Case notes reviews:

- Clinical coders will provide the relevant patient notes to reviewers.
- The review should be to provide assurance on the quality of care and an assessment of whether the death may have been avoided, any learning points and improvements required and recorded on the electronic mortality reporting tool.
- If concerns about the standard of care are found then the case should be reviewed at a specialty mortality and morbidity meeting and recorded in the minutes and discussed with a member of the Mortality Surveillance Group.

Reporting findings:

- A report should be written to demonstrate the methodology, findings, learning and recommendations along with improvement actions.
- The identified lead should present the report and findings to the Mortality Surveillance Group.

2.6 Learning from deaths

- Executive and Non-Executive Directors must ensure the mortality review process is robust with a focus on learning which can withstand external scrutiny and learning leads to meaningful and effective actions to improve patient safety and experience.
- A mortality dashboard must show outcomes at Trust and Directorate level and be examined at the executive performance meeting. The mortality dashboard must be presented to a public facing Board quarterly. The information published must be a fair and accurate reflection of achievements and challenges.
- The chair of the Mortality Surveillance Group is responsible for publishing a regular newsletter and making it available on the intranet and to Directorate Management Teams.
- The minutes of mortality and morbidity meetings must be shared with all relevant clinicians within the department and with the Directorate Management Teams.

3. Patient Information

Maternity and Neonatal Services – When your baby dies information leaflet – appendix 7.5

What to do when someone dies in hospital information leaflet – appendix 9.

Bereavement survey (will be available in October 2017) – appendix 10

4. Audit

4.1 Audit Indicators

4.2 Mortality dashboard indicators:

1. Crude death rate – the total number of elective and non-elective deaths including those with a palliative care code.
2. Number of deaths within 48 hours of admission.
3. Percentage of deaths with a palliative care code.
4. Number and percentage of deaths with a co-morbidity code of zero.
5. The number of deaths reviewed.
6. Total number of deaths with more than a 50% chance (strong and definite avoidability) of being due to problems in care.
7. Number of deaths where a serious incident inquiry was commissioned.
8. Number of deaths of patients with a learning disability.
9. Number of deaths of people with a learning disability reviewed.
10. Number of deaths of people with a learning disability reported to the LeDeR programme.
11. Total number of deaths of patients with a learning disability with more than a 50% chance (strong and definite avoidability) of being due to problems in care.
12. HSMR
13. Weekend HSMR
14. SHMI quarterly
15. SHMI adjusted for palliative care quarterly
16. Site specific SHMI (acute Trust and Hospice)
17. Deaths in high risk groups – stroke, hip fracture and sepsis per month
18. Highest causes of death (top 3) from the admission diagnosis
19. Number and name of new CUSUM alerts
20. Number and name of CUSUM alerts reviewed

4.3 Bereavement survey

Bereavement survey – see appendix 10.

4.4 User Involvement

Information will be drawn from a number of sources such as real-time feedback, complaints and concerns, national in-patient survey results, VOICEs survey, National Care of the Dying Audit.

5. Evidence Base

5.1 Sources of information

1. Care Quality Commission (2016); Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England.
2. Hogan et al (2012); Preventable deaths due to problems in care in English acute hospitals; a retrospective case record review study. British Medical Journal Qual Saf 2012: 21: 737-45
3. Hogan et al (2015); Avoidability of hospital deaths and association with hospital-wide mortality ratios; a retrospective case record. British Medical Journal 2015: 351:h3239.
4. Learning Disabilities Mortality Review (LeDeR) progamme
5. National Quality Board (2017): National Guidance on Learning from deaths: a framework for NHS Trusts and NHS Foundation Trust on identifying, reporting, investigation and learning from deaths in care.
6. NHS England (2016):Mortality Governance Guide
7. Salisbury NHS Foundation Trust (2017): Integrated Governance Framework and Accountability Framework
8. Salisbury NHS Foundation Trust (2016) Mortality and morbidity meeting standards and guidelines

5.2 Summary of evidence, review and recommendations

NHS England have made it clear that the national guidance on learning from deaths must be implemented. The Trust Board needs to be assured that deaths are reviewed and changes are made in response to learning to improve the quality of care. Trusts are required to report quarterly with specified information on deaths and demonstrate learning. The report must be presented to a public Board meeting.

6. Appendices

Appendix 1	Mortality screening form	Appendix 1
Appendix 2	Mortality screening prompt list	Appendix 2
Appendix 3	Mortality review process (flowchart)	Appendix 3
Appendix 4	Deaths of patients with learning disabilities standard operating procedure	Appendix 4
Appendix 5	Deaths of patients with severe mental illness or detained under the Mental Health Act standard operating procedure	Appendix 5
Appendix 6	Deaths of children and young people - Wiltshire and Swindon Child Death process	Appendix 6
Appendix 7.1	Review of stillbirth and neonatal death process	Appendix 7.1
Appendix 7.2	Perinatal mortality meeting terms of reference	Appendix 7.2
Appendix 7.3	Neonatal mortality review template	Appendix 7.3
Appendix 7.4	Pregnancy loss – sensitive disposal and handling	
Appendix 7.5	When your baby dies parents information leaflet	
Appendix 8	Action in the event of a Maternal death	
Appendix 9	What to do when someone dies in hospital relative information leaflet	
Appendix 10	Bereavement survey	Appendix 10
Appendix 11	Mortality and morbidity meeting standards and guidelines	
Appendix 12	Mortality and morbidity meeting minutes template	

Document Owner	Claire Gorzanski
Department	Clinical Governance
Review Date	22/08/2020
Document Status	Current
Revision Number	1.1