Trust Policy

University Hospitals Plymouth NHS Trust

Mortality Review Policy

Issue Date	Review Date	Version
Oct 2021	Oct 2023	V2

Purpose

To set out the procedure for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

The mortality review process ensures that there is 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.

Who should read this document?

All healthcare professionals should be involved in mortality review processes, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

Key Messages

The focus is on ensuring the Trusts mechanisms for mortality review are strong and effective in protecting patients from harm.

To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

Core accountabilities	
Owner	Deputy Medical Director
Review	Mortality Review Group/ Safety & Quality Committee
Ratification	Medical Director
Dissemination	Safety & Quality Committee
Compliance	Safety & Quality Committee

Links to other policies and procedures

To be read in conjunction with;

- Incident Management Policy and Procedures
- Care of the Deceased Patient Policy

Version History

V1	September 2017	New Policy
V2	September 2021	Full review, addition of Medical Examiner role.

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

Many people treated within the NHS will die whilst under the care of a hospital often following excellent care provided by the NHS in the months or years leading up to their death. However, in a minority of cases, some patients may experience care which does not reach those high standards and some may even receive poor quality of care provision. This usually results from multiple contributory factors, which may include poor leadership and system-wide failures and most commonly failures in communication recognising that NHS staff frequently work tirelessly under increasing pressures to deliver safe, high quality healthcare.

When mistakes happen, it is important that providers working with their partners do more to understand the causes of such failures in care and use that learning to contribute to system wide improvement in order to prevent recurrence.

Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon and so require streamlined processes to support system change

Concentrating attention on the factors that adversely impact on the quality of patient deaths and in some cases contribute to death, will impact positively on all patients; reducing harm and complications, length of stay and readmission rates through improving pathways of care, by reducing variability of care delivery, and by interventions such as early recognition and escalation of deterioration.

Systematic evaluation and review of patient deaths help to identify examples where processes and care can be improved by understanding the care delivered to those whose in whom death is expected and inevitable to ensure they receive optimal end of life care.

2 Purpose

This policy will provide guidance for all clinical staff in all specialities involved in mortality reviews. Implementation of the policy should be supported by administrative and managerial staff as applicable**.**
The aim of the mortality review process is to:

- Identify and minimise ‘avoidable’ deaths within the Trust.
- Improve the experience of patient’s families and carers through better opportunities for involvement in investigations and reviews.
- Ensure clear reporting mechanisms are in place, to escalate any areas of concern identified from mortality reviews and at mortality and morbidity meetings, so that the organisation is aware and can ensure appropriate learning and action is taken.
- Ensure mortality monitoring data is analysed and acted upon as appropriate.
- Promote organisational learning and improvement by supporting any changes in clinical practice that are needed to improve care using case record reviews.

3 Definitions

The following definitions apply for the purposes of this guidance;

Avoidable/Preventable: These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.

Case note and patient care structured judgement Review: The application of a case record/note review using a structured judgement tool to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened.

Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of structured judgement review and determined more likely than not to have resulted from problems in healthcare provision and therefore to have been potentially avoidable.

Investigation: The act or process of investigation; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation – in order to identify problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

LeDeR: All deaths of people with LD death (aged 4 and over) in UHP are subject to an external mortality review and reported to Learning Disabilities Mortality Review (LeDeR) Programme by the LDL team.

Mortality: For the purpose of this document, mortality relates to any in hospital death or any death occurring within 30 days of a surgical procedure (surgical specialties only).

Structured Judgement review: A tool designed by the RCP used to systematically and efficiently review the case notes of any patient who has died, in whom any issues have been raised regarding their care through the medical examiner system, the coronial system or by families who have lost loved ones and who believe care did not achieve the required standard. The information gained will then inform the clinicians and service lines as well as the clinical lead, to determine whether there is the need for further investigation and to determine whether there are systematic failures in care provision that might be improved

Serious Incident Requiring Investigation (SIRI): An accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death.

4 Duties

The **Chief Executive** has overall responsibility for monitoring mortality rates on behalf of the Board of Directors for the Trust.

Medical Director is responsible for the learning from deaths agenda and assures the Board that the mortality review process is functioning correctly. Ensuring that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.

Non-Executive Director with responsibility for Safety & Quality is responsible for oversight of progress from the learning from deaths agenda. The Non-Executive Director

has a key role in ensuring the Trust is learning from problems in healthcare identified through reviewing or investigating deaths.

Care Group Managers and Clinical Directors ensure that appropriate multi-disciplinary Mortality & Morbidity (M&M) meetings take place in all Service Lines and meetings are fully documented. Through Service Line assurance process, Care Group Management Teams will confirm that SJR reviews are being completed and learning is identified. The Care Group Management Team will take action within Service Lines where the process is not being adhered to.

Care Group Quality Managers ensure that the Care Group Managers and Clinical Directors have sufficient information to be assured the correct processes are in place in Service Lines. Quality Managers will escalate any clinical concerns highlighted as a result of a review and support service lines with any actions required. Quality Managers will feed any escalations from the Risk & Incident team when Service Lines aren't carrying out the required reviewed in a timely fashion.

Medical staff are required to engage and participate fully in the mortality review process by attending all Mortality & Morbidity (M&M) meetings that are relevant to their practice and undertake tii ti timely retrospective care record reviews to help identify if a death was more likely than not to have been contributed to by problems of care.

Nurses, allied health professionals and other clinical staff
All healthcare professionals should be involved in mortality reviews meetings, as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

Mortality Review Meeting is a monthly forum responsible for;

- Providing assurance to the Trust Board on patient mortality based on review of care received by those who die.
- Reviewing structured judgement reviews and serious incident investigations 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 relevant staff.
- Ensuring the mortality governance is maintained and meets the requirements of the recommended evidenced based practice.

The **Risk & Incident Team** are responsible for;

- Requesting the patient notes and supplying the relevant patient details, including incident and post mortem information, to the clinical nominated to undertake the Structured Judgement Review (SJR).
- Maintaining a database of completed structured judgement reviews and feeding back the reported outcomes to the clinical leads for each area.
- Analysis of the database to identify themes and trends.
- Monitoring identified learning outcomes and associated action plans.
- Ensuring the Duty of Candour has been addressed and families are involved in the SJR investigation process if they express a wish to be and that they are provided with the report and any subsequent action plan. The Risk & Incident Team will act as the one point of contact for the bereaved family and/or carers.

The **Bereavement Team** are responsible for informing bereaved families of their right to raise concerns about the quality of care provided to their family member. The team will

offer support and guidance and will obtain legal advice for families and carers when required.

The **Medical Examiner's office** is responsible for reviewing every death within the hospital and those that take place within 30 days of admission.

The medical examiner team highlight those cases where a structured judgement review is indicated. When appropriate they will inform the coroner of cases where coronial review may be required and inform the risk and incident team of the same. The team will record the patient details and request the SJR in line with the current processes of the hospital.

5 Key elements

There are deaths that will be subject to further review by the Trust, looking at the care provided to the deceased as recorded in their medical notes in order to identify any learning.

To ensure objectivity, SJR reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge.

A framework for the minimum requirements can be found detailed below and the mortality review process can be found in Appendix 1 (Page 13).

When a death meets Serious Incident criteria, there is no need to delay the onset of a formal RCA investigation until the SJR review has been undertaken. If not already reported on the Datix system any cases where death is identified as potentially avoidable, or where death may have been precipitated, must be reported and the Serious Incident investigation process will be initiated by the Risk & Incident Team.

Conducting Mortality Reviews: A framework for the minimum requirements of the mortality review process are detailed below;				
Level of review	**Time-scales**	**Which deaths?**	**Tool required**	**Level of Investigation req.**
Medical examiner	Review of death 1 working day 5 days to registration of death.	➢ **All in Hospital deaths** ➢ All in-patients who have **died within 30 days of leaving Hospital.** ➢ Non coronial deaths ➢ Coronial deaths where there is uncertainty in coming to \ definitive cause of death ➢ Uncertainty in cause of death When pt has mental illness leder safeguarding, family concerns, target groups, eg covidareas for scrutiny	National ME tool. ME team Provides quarterly return	If the medical examiner notes concerns or uncertainty the Risk & Incident team will initiate a review using the SJR methodology.
SJR	30 working days	➢ Medical examiner team determine need for SJR ➢ Deaths that have been **referred to the Coroner when Doctors cannot readily certifyas being due to natural causes.** ➢ Review of care provided to patients who were not under our care at the time of death but **another organisation suggests the Trust should review the care provided to the patient in the past.** ➢ Deaths where **bereaved families have raised significant concern about the qualityof care provision.** ➢ All deaths in a **service speciality, particular diagnosis or treatment group wherean 'alarm' has been raised** with the provider through whatever means (for examplevia a Summary Hospital-level Mortality Indicator or other elevated mortality alert) ➢ In-patient/ out-patient deaths of those with **learning disabilities** (Ages 4 -74 years)* ➢ In-patient/ out-patient deaths of those with **severe mental illness.** ➢ All deaths where patients are **not expected to die**, for example following relevant electiveprocedures. ➢ Deaths where **learning will inform the Trust's existing/ planned improvementwork.** ➢ **Infant/ Child deaths, stillbirths and maternal deaths** (during or up to 42 days after the end of pregnancy.	Structured Judgement Review (SJR)	If an SJR identifies a problem in care that meets the definition for a patient safety incident the Mortality Review Group (MRG)will review the case record review and confirm level of further investigation required.
SIRI	60 workingdays	➢ Deaths identified as 'avoidable' by MRG/SJR lead following SJR (Score 1 or 2). ➢ Acts and/or omissions occurring as part of NHS-funded healthcare that result in: **Unexpected** or **avoidable death** of one or more people. This includes; - Suicide; and - Homicide by a person in receipt of mental health care within the recent past.	Root Cause Analysis (RCA) Investigation	**The Serious Incident Requiring Investigation (SIRI) Procedure should be followed.**
**All deaths of people with learning disabilities are subject to review using LeDeR methodology (Learning Disabilities Mortality Review). The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017.*				

Supporting bereaved families/carers

All staff should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following principles. Bereaved families and carers;

- Should be treated as equal partners following a bereavement;
- Must always receive a clear, honest, compassionate and sensitive response;
- Should receive a high standard of bereavement care;
- Should be informed of their right to raise concerns about the quality of care provided to theirloved one;
- Views should be used to help to inform decisions about whether a review or investigation is needed;
- Should receive timely, responsive contact and support in all aspects of an investigationprocess;
- Should be involved in an investigation to the extent and at whatever stage they wish to beinvolved.

When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including explaining what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis. To fulfil the duty of candour this information will also be provided in writing.

Bereaved families and carers will expect to know: what happened: how; to the extent possible at the time, why it happened and what can be done to stop it happening again to someone else.

Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation.

When to refer to the coroner

- A doctor did not treat the person during their last illness
- A doctor did not see or treat the person for the condition from which they died within 28 days of death
- The cause of death was sudden, violent or unnatural such as an accident, or suicide
- The cause of death was murder
- The cause of death was an industrial disease of the lungs such as asbestosis
- The death occurred in any other circumstances that may require investigation

A death in hospital should be reported if:

- there is a question of negligence or misadventure about the treatment of the person who died
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause
- the patient died as the result of the administration of an anaesthetic

A death should be reported to a Coroner by the police, when:

- A dead body is found
- Death is unexpected or unexplained
- A death occurs in suspicious circumstances

After a death is reported:
A Coroner will first gather information to investigate whether a death was due to natural causes and if a doctor can certify the medical cause of death.

The Coroner will ask the police to gather the information about the death. This will usually include speaking to the family of the deceased, anyone who was caring for the deceased and anyone who was there when the death happened.

If the reason why a doctor cannot certify the death is simply because they have not treated the patient in the last 28 days, then the Coroner will discuss the cause of death with the doctor. If a Coroner is satisfied that death was from natural causes and no further investigation is necessary, then they may accept the medical cause of death that a doctor gives and issue a Coroner's notification to allow the death to be registered.

If a doctor cannot certify the medical cause of death then a Coroner will investigate the death and may order a post-mortem examination to be carried out.

Identifying the body:
If the Coroner orders a post-mortem examination then a member of the family will be asked to formally identify the body. This could be to the police at the place where the death has happened or at the mortuary before the post-mortem examination is carried out.

The Coroner will normally ask the police to tell relatives of the need for a post-mortem examination unless this is not possible or would unduly delay the examination.

The consent of the next of kin is not required for a Coroners post-mortem examination to take place.

The next of kin can be represented at the examination by a doctor of their choice.

6 Overall Responsibility for the Document

The Safety & Quality Committee are responsible for this mortality review policy.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Safety & Quality Committee and ratified by the Medical Director.

Non-significant amendments to this document may be made, under delegated authority from the Medical Director, by the nominated owner. These must be ratified by the Medical Director and should be reported, retrospectively, to the approving Safety & Quality Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Executive Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

The Trust is required to collect and publish on a quarterly basis specified information on deaths to the public board meetings. The data will include the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record reviews. Of these deaths, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

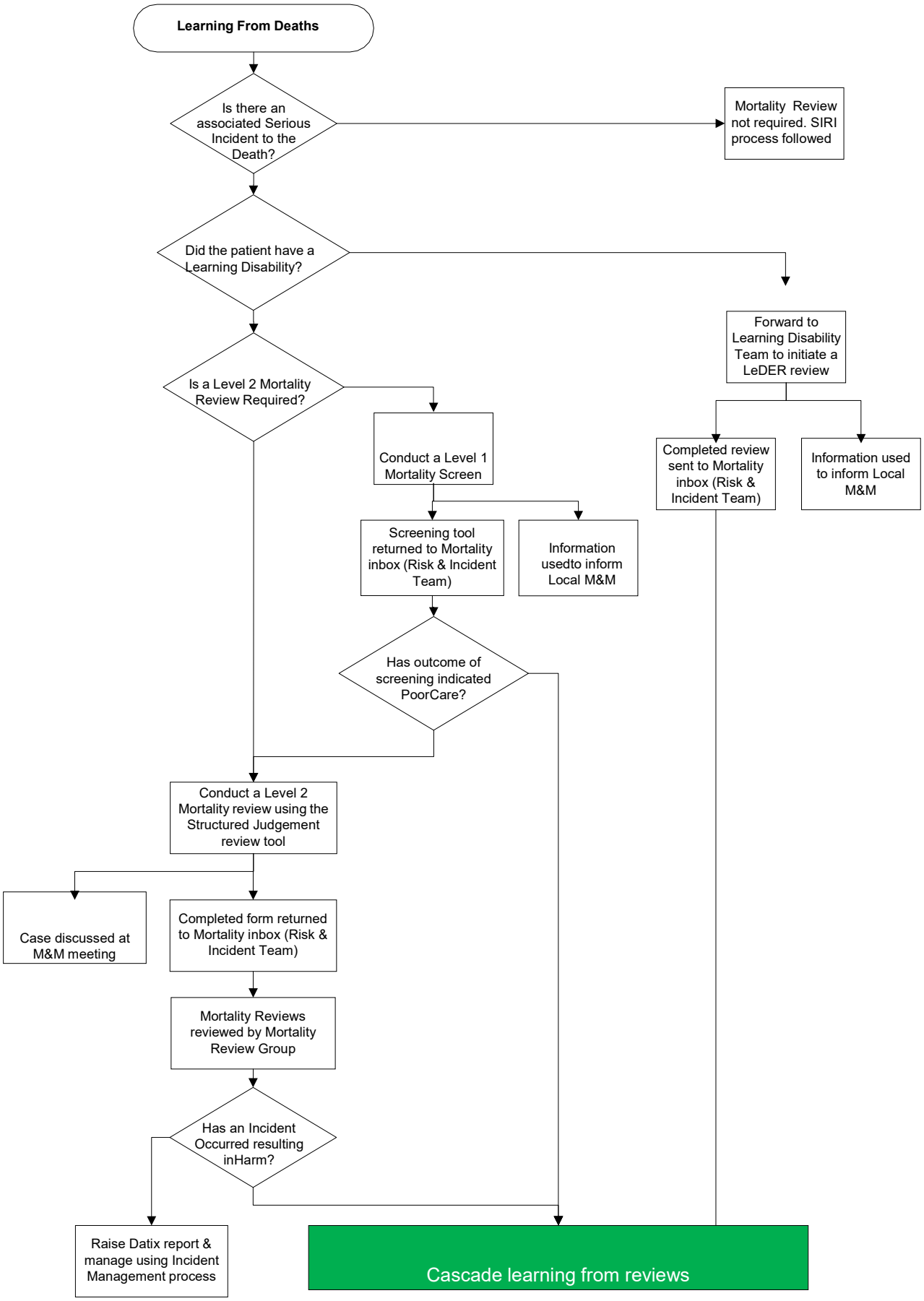
Summarised data will be included in the Trust's Quality Account from June 2018 which will include evidence of learning and action taken as a result and an assessment of the impact of actions that the Trust has taken.

10 References and Associated Documentation

1. Horgan H, Healey F, Neale G, et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Quality and Safety (2012). Doi: 10.1136/bmjqs-2012-001159.
2. Higginson J, Walters R, Fulop N. Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety? BMJ Quality and Safety (2012). doi:10.1136/bmjqs-2011-000603.
3. Healthcare Commission, Investigation Into Mid Staffordshire NHS Foundation Trust, March 2009.
4. NHS England, Mortality Governance Guide.
5. Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015).
6. 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.
7. National Quality Board National Guidance on Learning from Deaths.

Mortality Review Process

Appendix 1



Dissemination Plan and Review Checklist | Appendix 2

Dissemination Plan	
Document Title	Mortality Review Policy
Date Finalised	October 2021
Previous Documents	
Action to retrieve old copies	Replaced from Trust Document Library

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff	Oct/November 2021	Information Governance StaffNet Page	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Equalities and Human Rights Impact Assessment | Appendix 3

Core Information	
Date	October 2021
Title	Mortality Review Policy
What are the aims, objectives & projected outcomes?	To set out the procedure for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.
Scope of the assessment	
This assessment covers the impact the project will have on the workforce (clinicians, admin staff and others) and patients.	
Collecting data	
Race	There is no evidence to suggest that there is a negative impact on race regarding this policy.
Religion	There is no evidence to suggest that there is a negative impact on Religion or belief and non-belief regarding this policy.
Disability	There is no evidence to suggest that there is a negative impact on Disability regarding this policy.
Sex	There is no evidence to suggest that there is a negative impact on Gender regarding this policy.
Gender Identity	There is no evidence to suggest that there is a negative impact on Gender Identity regarding this policy.
Sexual Orientation	There is no evidence to suggest that there is a negative impact on Sexual Orientation regarding this policy.
Age	There is no evidence to suggest that there is a negative impact on Age regarding this policy.
Socio-Economic	There is no evidence to suggest that there is a negative impact on Socio-Economics regarding this policy.
Human Rights	There is no evidence to suggest that there is a negative impact on Human Rights regarding this policy.
What are the overall trends/patterns in the above data?	No trends or patterns identified at this stage.
Specific issues and data gaps that may need to be addressed through consultation or further research	There are no other issues or data gaps. Should any arise then an early and prompt adjustment to the policy will be made through the control of the Safety & Quality Committee.

Involving and consulting stakeholders	
Internal involvement and consultation	Internal consultation and involvement was undertaken via email and various forums with the following staff groups; Mortality Review Group Safety & Quality Committee Trust Board.
External involvement and consultation	NHS Improvement.

Impact Assessment	
Overall assessment and analysis of the evidence	No impact.

Action Plan

Action	Owner	Risks	Completion Date	Progress update