

Mortality Review Policy

Issue Date	Review Date	Version
Sept 2017	Sept 2020	V1

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	Risk & Incident Manager
Review	Safety & Quality Committee and Trust Board
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
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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 on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

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1 Introduction

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributor factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high quality healthcare.

When mistakes happen, providers working with their partners needs to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

Concentrating attention on the factors that cause deaths will impact positively on all patients; reducing harm and 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.

Retrospective case note reviews help to identify examples where processes can be improved and to gain an understanding of the care delivered to those whose 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 staff and managers 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 resulting from 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 Record Review: The application of a case record/note review 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 case record/ note review and determined more likely than not to have resulted from problems in healthcare 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 the 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 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.

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).

Mortality Screening Tool: Case note methodology used to review Level 1 deaths.

PRISM 2 (Preventable Incidents, Survival and Mortality Study): The Trust's current case note methodology approach being used to undertake in-depth mortality reviews.

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

Structured Judgement Review (SJR): Case note methodology approach being rolled out by the Royal College of Physicians.

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. To ensure 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 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 mortality screen 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 library of completed case record 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.

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, case record 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 12).

When a death meets Serious Incident criteria, there is no need to delay the onset of a formal RCA investigation until the case record 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.
Level 1	20 working days	<ul style="list-style-type: none"> ➤ All in Hospital deaths ➤ A selection of in-patients who have died within 30 days of leaving Hospital. ➤ A selection of patients whose deaths may have been expected to review end of life care provision. 	Mortality Screening Tool	<p>Level 1 mortality review process should be followed.</p> <p>If the screening tool concludes the death as Grades 1 or 2, the Risk & Incident team will initiate a Level 2 case record review using the SJR methodology.</p>
Level 2	35 working days	<ul style="list-style-type: none"> ➤ Screening tool deaths graded as 1 or 2. ➤ Deaths that have been referred to the Coroner when Doctors cannot readily certify as being due to natural causes. ➤ Review 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 quality of care provision. ➤ All deaths in a service speciality, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via 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 in relevant elective procedures. ➤ Deaths where learning will inform the Trust’s existing/ planned improvement work. ➤ Infant/ Child deaths, stillbirths and maternal deaths (during or up to 42 days after the end of pregnancy). 	Structured Judgement Review (SJR)	<p>Level 2 mortality review process should be followed.</p> <p>If an SJR identifies a problem in care that meets the definition for a patient safety incident (Score 1 or 2), the Mortality Review Group (MRG) will review the case record review and confirm level of further investigation required.</p>
SIRI	60 working days	<ul style="list-style-type: none"> ➤ Deaths identified as ‘avoidable’ by MRG 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; <ul style="list-style-type: none"> - Suicide; and - Homicide by a person in receipt of mental health care within the recent past. 	Root Cause Analysis (RCA) Investigation	<p>The Serious Incident Requiring Investigation (SIRI) Procedure should be followed.</p>

**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 their loved one;
- Views should help to inform decisions about whether a review or investigation is needed;
- Should receive timely, responsive contact and support in all aspects of an investigation process;
- Should be involved in an investigation to the extent, at whatever stage they wish to be involved.

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.

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.

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 Trust Wide 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 approved 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 author. 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, currently the 'Vital Signs' electronic newsletter.

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

The document author(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.

References

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.

Dissemination Plan			
Document Title	Mortality Review Policy		
Date Finalised	22 nd September 2017		
Previous Documents			
Action to retrieve old copies	Not Applicable – New Policy		
Dissemination Plan			
Recipient(s)	When	How	Responsibility
All Trust staff		Vital Signs	Information Governance Team
External Organisations/ Public		External Trust Website	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	

Core Information	
Date	22 nd September 2017
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