Mid and South Essex
Success Regime

Mid & South Essex Learning from Deaths Policy	Policy Register No: 17019 Status: Public

Developed in response to:	Best Practice, NQB Learning from Deaths
Contributes to CQC Fundamental Standard:	17

Consulted With	Post/Committee/Group	Date
	Mortality Review Groups at each site	August 2017
	Senior Management Group	14th September 2017
Professionally Approved By	Chief Medical Officer	15th September 2017

Version Number	1.0
Issuing Directorate	Governance
Ratified by:	DRAG Chairmans Action
Ratified on:	22nd September 2017
Executive Management Group Sign Off Date	October 2017
Implementation Date	22nd September 2017
Next Review Date	August 2020
Author/Contact for Information	Helen Clarke, Head of Governance MEHT
Policy to be followed by (target staff)	Medical Staff, Senior Nursing Staff, Clinical Coding, Informatics and Corporate Governance at each site
Distribution Method	Site Intranet & Website
Related Trust Policies (to be read in conjunction with)	Risk Management Policies Serious Incidents Requiring Investigation Policies Duty of Candour / Being Open Polices Trust Child Death Review and Rapid Response policy

Document Review History

Version No	Authored/Reviewed by	Active Date
1.0	Helen Clarke, Head of Governance MEHT	22 September 2017

Index

1.0 Purpose

1.1 All NHS organisations are required to demonstrate how they respond to, and learn from, deaths of people who die while in their care. Our aim is to continue to build upon an open and transparent culture by developing our mortality governance so that our staff are supported to review and learn from deaths and then take effective action to make improvements.

1.2 The Mortality Review Policy sets out how the Trusts within the Success Regime respond to deaths of patients who die under their care.

1.3 This policy provides guidance for all staff involved in mortality reviews including clinicians, clinical coding, governance, informatics analysts, end-of-life and palliative care teams and clinical audit and effectiveness staff.

1.4 The purpose of the policy is to standardise the approach across the 3 sites and ensure the requirements of national guidance are met.

1. 5 The aim of the mortality review process is to:

- Identify and minimise deaths due to problems in care in all Trust hospital sites across the Success Regime
- Identify and learn from episodes of sub-optimal care
- Support the review of end of life care and ensure that patients' wishes have been identified and met
- Engage with patients' families and carers and recognise their insights as a source of learning, improving their opportunities for raising concerns and involvement in investigations and reviews
- Identify and minimise avoidable admissions or late presentation
- Enable informed reporting with a transparent methodology
- Ensure accurate, timely and reliable mortality statistics
- Promote organisational learning and improvement.

2.0 Background

2.1 Concern about patient safety and scrutiny of mortality rates intensified with high-profile investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

2.2 Effective clinical audit and peer review processes incorporating analysis of Mortality and Morbidity (M&M) contribute to improved patient safety. The specialty 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.

2.3 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.

2.4 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.

2.5 A formalised process will also address the requirements of the Care Quality Commission's 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 and the National Quality Board's Learning from Deaths Guidance.

2.6 This standardised trust-wide process integrating mortality peer 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.

3.0 Scope

3.1 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
- Informatics Analysts
- Governance Staff

3.2 The mortality peer review process is applicable to:

- Nationally mandated patient groups identified by the National Quality Board's Learning from Deaths guidance
- Individual deaths identified by the Medical Examiner
- Deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision or as a result of the Inquest process
- Local mandated diagnosis groups identified by the Mortality Review Group
- A further sample of deaths that do not fit the identified categories to provide an overview of where learning and improvement is needed most overall

3.3 Mandated patient groups for mortality review

- Deaths where significant concerns have been raised about the quality of care
- Deaths of individuals with learning disabilities will be undertaken in accordance with the Learning Disabilities Mortality Review (LeDeR) programme. Current guidance states that there is an expectation that the organisation will continue to review deaths in this cohort in accordance with local arrangements.
- Death of an individual detained under the Mental Health Act or with a severe Mental illness
- Death of an infant or child (to be managed under the Trust Child Death Review and Rapid Response policy)
- Stillbirth or maternal death
- Deaths in a service specialty / diagnosis / treatment group where mortality alert has been raised
- Deaths where learning will inform improvement work
- Unexpected deaths including patients admitted for elective care
- Sample of other deaths
- Any death linked to an Inquest and issue of a Regulation 28 Report on action to prevent

future deaths

3.4 The mortality peer review process forms one aspect of the Trust's quality improvement work. The aim is that all nationally and locally mandated in-hospital deaths will be peer reviewed using an amended version of the Royal College of Physicians Structured Judgement template. This template may be amended for specific patient groups to ensure effective review against relevant standards.

4.0 Equality & Human Rights Impact Statement

4.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

5.0 Responsibilities

5.1 Chief Executive

5.1.1 As the Accountable Officer for the 3 organisations making up the Essex Success Regime, the Chief Executive has overall responsibility for ensuring processes are in place for effective mortality review. This responsibility is delegated to the Chief Medical Officer.

5.2 Chief Medical Officer (CMO)

5.2.1 The CMO has executive director responsibility for the learning from deaths agenda and specifically for the mortality review process and will provide regular quarterly reports on outcomes and findings of the review process to the Joint Executive Group.

5.2.2 The CMO has overall responsibility for ensuring staff have the required skills and training to review and investigate deaths to a high standard. The CMO will ensure that there is a clear process through which delegated leaders hold reviewers to account for their performance regarding the quality and timeliness of the reviews and the implementation of learning actions.

5.2.3 The CMO will work with the site leads for mortality to ensure a consistent and effective process is embedded across all sites.

5.3 Site Non Executive Director (NED) for the learning from deaths agenda

5.3.1 The identified NED has responsibility for providing oversight of progress with the learning from deaths agenda ensuring:

- They have a good understanding of the process and provide challenge and scrutiny
- That these processes are robust and meet national requirements
- That information published reflects challenges and achievements
- Quality improvement remains the purpose of the exercise and that meaningful and effective actions are implemented to improve patient safety and experience.

5.4 Site Leads for mortality review

5.4.1 Each Trust will identify a Mortality Lead who will chair the site Mortality Review Group (MRG).

5.4.2 The site lead for mortality will ensure the requirements of this policy and the site MRG

terms of reference are met and that outcomes and key metrics are reported to the public Board quarterly and to the Trust Commissioners.

5.4.3 The Site Mortality Lead will ensure training and advice is available for colleagues involved with the mortality review process.

5.4.4 The Site Mortality Lead will ensure that external mortality alerts are investigated and any associated concerns are resolved.

5.4.5 The Site Mortality Lead will ensure relevant learning is shared across the organisation and with the CMO ensure learning is shared across the 3 sites.

5.4.6 The Site Mortality Lead will raise any identified risk onto the Trust Risk Assurance Framework via the Mortality Review Group where it will be reviewed as part of the risk management process.

5.4.7 The Site Mortality lead will report on learning from deaths within the annual Quality Account.

5.5 Divisional Directors

Divisional Directors are responsible for establishing a governance process for receiving regular mortality reports from specialty mortality groups and ensuring that learning is captured and improvement actions progressed and so demonstrate compliance with Care Quality Commission (CQC) Regulation 17 'Good Governance'. Specifically they will:

- Ensure appropriate mortality review occurs within their areas and is reported to the Mortality Review Group within the agreed template to capture required metrics
- Ensure learning from Specialty Mortality and Morbidity meetings
- Appoint specialty mortality leads as required
- Act on the outcomes and findings of the review process to improve services for patients
- Attend the Mortality Review Group meeting

5.6 Divisional Mortality/Governance Leads

- Ensure appropriate mortality review occurs within their areas
- Appoint specialty mortality leads as required
- Act on the outcomes and findings of the review process to improve services for patients.

5.6 Senior Nursing staff

Senior Nursing staff will be responsible for participating in mortality peer reviews wherever possible, either in person or by nominated staff being available for advice on nursing issues.

5.7 Clinical Coding Staff

Clinical Coding staff will be responsible for participating in mortality peer reviews where coding issues have been identified.

5.8 Informatics Analysts

The Informatics Analysts will be responsible for:

- Providing monthly mortality trend data to the MRG
- Providing a monthly list of Trust deaths to the Trust Mortality Lead, Clinical Coding, Patient Safety Manager
- Providing patient lists to the Clinical Coding Team as required.

5.9 Medical Examiner

Where in place, the Medical Examiners will be responsible for:

- Reviewing all inpatient adult deaths and ensuring MCCD is completed where possible and after discussion with Coroner where indicated
- Referral of deaths to Coroner
- Highlighting any incidents in care via Datix if not already done
- Referring cases for Mortality Review where indicated
- Reporting monthly into Mortality Review Group

5.10 Mortality Review Group (MRG)

5.10.1 The Mortality Review Group will support the Trust in providing assurance that mortality is proactively monitored, reviewed, investigated and supports quality improvement.

5.10.2 The terms of reference for the MRG are included in appendix 1.

5.11 Governance, Clinical Effectiveness and Complaints Teams, and Divisional Governance Facilitators

5.11.1 Arrangements vary across the 3 sites however support staff will be responsible for:
- Supporting the MRG function
- Requesting patient notes and supplying the relevant patient details, including Incident, Complaint and post mortem information, to the nominated Clinicians identified to complete the review.

6.0 Definitions

6.1 Mortality rate

- **Crude Mortality**
  The crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted.

- **HSMR**
  The HSMR scoring system works by taking the crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc.
  By taking these factors in to account, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate.

- **Summary Hospital-level Mortality Indicator (SHMI)**
  The (SHMI) is a score that reports on mortality rates at trust-level across the NHS in England, using a standard and transparent methodology. It is produced and published quarterly as an official statistic NHS Digital.
  The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI includes deaths following a patient's discharge (within 30 days).

6.2 Case record review

Review of patient records using a structured review template to establish whether there were any problems in the care provided to the patient who died in order to learn from what happened.

6.3 Death due to a problem in care

A death that has been clinically assessed using recognised methodology of case note review and determined to be more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

6.4 Investigation

A systematic analysis of what happened and why. In the context of mortality review this will be triggered following a structured review that identified significant contributory failures of care and will be undertaken in accordance with the Serious Incident policy.

6.5 Duty of Candour

Duty of Candour is a legal and moral duty on NHS organisations to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

7.0 Clinical Coding

7.1 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 and forms the basis of mortality statistics.

7.2. 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.

7.3. This is supported as part of the mortality peer 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.

8.0 Process for Mortality Review

8.1 The process for the conduct of mortality reviews on each site are outlined in the flow charts at Appendix 2. Key steps are described below.

8.2 Notification of patient deaths

- Patient deaths are notified through the Bereavement Office and/or the Informatics Team, including post-mortem information where known
- Checks are made by the Governance Team against any incidents recorded on DATIX and these are reported to divisions to ensure the data is reflected in their divisional reports to MRG
- At the end of each month, data of all in-hospital deaths that occurred together with incidents, complaints and post mortem information is forwarded to the Site Mortality Lead for information and to the Divisional Directors who will be responsible for ensuring completion of the mortality reviews and monthly MRG report.
- This data is also forwarded to the relevant support teams
- Where concerns have been raised about a patient's care and treatment, i.e. through an incident report or complaint or through concerns being raised, 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

8.3 Mortality reviews

- The relevant Divisional Director should nominate peer reviewers to carry out the mortality reviews. They should also inform the Senior Nurse, Clinical Coding, Informatics Team and Governance Team which clinicians have been nominated
- The reviews should be completed by the nominated reviewers and relevant senior nurse who should work together and carry out a holistic review of medical and nursing care.
- The findings of the mortality reviews should be recorded on the mortality review pro forma and the findings collated within the monthly divisional report.
- All completed mortality peer reviews should also be sent to the relevant corporate team.

8.4 Clinical coding

- Where clinical coding issues have been identified the notes should be sent to the Head of Clinical Coding.
- The Site Mortality Lead 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 and be included within the divisional monthly mortality report.

8.5 Outcomes

- Where concerns have been identified but no incident has previously been reported, the appropriate Divisional Director should be informed by the nominated reviewer and an incident report with brief details should be raised on the Trust's incident reporting system 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 their regular specialty / departmental M&M meetings.
- Completed mortality reviews should be evaluated and the findings reported to the specialty M&M meetings and divisional governance days.
- 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 Group within the divisional report.
- Mortality reviews and in-depth reviews from M&M meetings should be used to inform any subsequent investigations.
- 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 Trusts' Duty of Candour Policies or via the Governance Teams.

9.0 Engaging with bereaved families and carers

9.1 Each Trust will develop processes to ensure that contact is made with bereaved families and carers to ensure:

- A high standard of timely bereavement care is provided
- They are informed of their right to raise concerns about the quality of care provided to their loved one
- Their views are taken into account in deciding whether mortality review is indicated
- They receive clear, honest and sensitive response to concerns
- Those who have experienced the investigation process are invited to work with the organisation involved to improve the process.

9.2 The requirements of the Trusts' Duty of candour policies should be met.

9.3 Where the bereaved family or carer raises significant concerns this should trigger a structured review and / investigation by the appropriate team as identified by the site lead for mortality. Once this decision has been made the bereaved family should:

- be made aware in person and in writing as soon as possible of the purpose, rationale and process for the investigation by the relevant clinician
- be kept fully and regularly informed in a way that they have agreed, of the process for the investigation.
- be asked their preference as to how and when they contribute to the process of the investigation including agreement to the terms of reference
- be provided with a single point of contact to provide timely updates including delays
- have an opportunity to respond to the findings and recommendations in any final reportbe informed and be informed of what processes have changed in the provision of future care.

10. Process for responding to a mortality alert

10.1 If there are concerns about mortality in any particular patient group, for example through a CQC alert or elevated HSMR for a particular diagnostic group, it will be necessary to undertake an in-depth case note review.

10.2 The MRG will monitor the mortality rates and any related alerts and should inform the Chief Medical Officer and Site Medical Director of the issues.

10.3 The correct cohort of patients should be identified by the Informatics 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.

10.4 The need for a full case note review should be approved by the Mortality Review Group at their next meeting.

- The Group 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 Informatics Analyst and sent to the Governance Support teams.
- Once the full case note review has been agreed, the CQC should be informed by the Trust that a review is being carried out due to a diagnosis group flagging.
- The Informatics Analyst should identify the relevant patients and the Governance support teams should request the 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 template and sent to the Governance Support team for collation.
- A report should be constructed demonstrating methodology, findings, learning and recommendations

- Reports from Informatics (superspells and demographics of the whole cohort) and Governance (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 Site Mortality Lead and Governance for action planning
- The identified lead should present the draft report and findings to the Mortality Review Group for approval

11. Mortality and Morbidity Meetings (M&M)

11.1 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.

11.2 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.

11.3 Key learning from M&M should be included in monthly Divisional Mortality reports to MRG.

12. Dissemination of Learning

12.1 It is essential that clinicians and other stakeholders are informed of the outcomes of the Mortality review Process if they are to learn and improve outcomes for patients.

12.2 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 will be developed and implemented by the Mortality Review Group.

12.3 Where relevant learning from the review process will be shared with the Patient's GP.

12.4 Key metrics on mortality review will be reported to the MRG, to the Site Directors and Board and to Commissioners.

13. Mortality Review policy compliance

13.1 Each Mortality Review Group will ensure that this policy is adhered to and will report an on-going review of compliance to each meeting.

13.2 Where areas of non-compliance are identified, the MRG will identify actions to address these and monitor their implementation.

14. Communication and Implementation

14.1 The policy will be published on the Trust's intranet and shared via the membership of the Mortality Review Group (MRG).

14.2 The MRG are responsible for the implementation of this policy and monitoring compliance against these requirements.

15. References

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
Learning Disabilities Mortality Review (LeDeR) programme Available at: http://www.bristol.ac.uk/sps/leder/
National Quality Board (May 2017), Learning from Deaths
NHS England, Mortality Governance Guide
Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
NHS England (April 2015), Serious Incident Framework Available at: https://improvement.nhs.uk/resources/serious-incident-framework/

Appendix 1 – MEHT Mortality Review Group, Terms of Reference.

DRAFT MRG TOR JUN17.doc

Appendix 2 MEHT Mortality Review Process flow chart