University Hospitals of Morecambe Bay NHS Foundation Trust

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	Status: Ratified
Scope: Consultants, Nursing Staff, Clinical Coding Staff, Clinical Audit & Effectiveness Staff, Quality Improvement Staff, Governance Staff	**Classification:** Organisational
Author / Title: Mrs Kim Wilson, Assistant Chief Nurse Patient Safety Unit Dr Shahedal Bari, Deputy Medical Director	**Responsibility:** Patient Safety Unit
Replaces: Version 1, Mortality Review Process, Corp/Proc/073	**Head of Department:** Dr David Walker, Medical Director
Validated By: Quality Committee Chair's Action	**Date:** 30/08/2017
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Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** **1-7** Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** **1,3,5,7** Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? ***Yes**

Document for Public Display: *Yes

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CONTENTS

BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

Mortality reviews are an established part of provision of high quality clinical care. The Trust is committed to continuous learning and service improvement and acknowledges that systematic mortality review has a crucial part in delivering the clinical quality agenda and providing assurance of quality improvement. This policy focuses on ensuring that the mechanisms for mortality review are effective in protecting patients from harm.

2. PURPOSE

This policy has been written to fulfil the requirements of local and national guidance and the recommendations from 3 key documents are incorporated into this policy which will identify how the Trust will internally undertake mortality reviews.

- Systematic failings at Mid-Staffordshire NHS Trust were identified by examining the implications of mortality rates. Analysis of all deaths within the hospital supports the Trusts response to the recommendations of the Francis 2 Report (HSMO, 2013).
- A recent Mersey Internal Audit Agency review of mortality processes at the Trust made a number of recommendations to improve current mortality review processes.
- National Guidance on Learning from Deaths, was published by the National Quality Board in March 2017, this key document outlines the principles of mortality reviewing expected of Trusts

It is principally the responsibility of the department and the consultant medical staff to conduct mortality reviews in order to identify any aspects of clinical care that may have had an impact on the final outcome for patients who have died within the Trust. Trust to ensure that there is a system and governance in place to ensure that this happens and the learnt lessons are shared amongst staff. The Academy of Royal Colleges produced guidance on how mortality reviews should be undertaken to improve quality of care, with a 3 year phased programme of training to introduce standardised methodology using Structured Judgement Reviews.

2.1 Main Aims

The aim of this policy is to set out clear roles and responsibilities to ensure that the Trust meets its obligations to undertake mortality reviews of a consistent quality. These include:

- Clinicians (including doctors, nurses, allied health professionals etc.) systematically use mortality reviews to provide assurance that the care provision within their service is of high quality and is safe; utilising lessons learned from these reviews to improve patient outcomes, where possible.
- Results of the process of reviewing mortality will collectively provide assurance that the Trust is doing all it can to learn from episodes of care where harm has occurred.
- Identify where clinical pathways, which are across the whole health economy, can affect patient care provision and ensure these are reviewed accordingly.
- Support the Trust data collection by ensuring clinical documentation surrounding diagnosis and co-morbidities are consistent and accurate.
- Use of details from the review of Cardiac Arrest calls that have resulted in patient death, to enhance the learning across all teams in relation to the causes of mortality.
- To ensure all areas where care can be improved or risk of harm (near-misses and misses) are identified and learnt from.

2.2 Secondary Aims

The mortality review process also aims to

- Review the quality of end of life care by ensuring that patients' wishes have been identified and met
- Improve the experience of patients' families and carers through better opportunities for involvement in investigations and reviews
- Identify and minimise avoidable admissions or late presentation

3. SCOPE

Mortality reviews are systematic retrospective case note and electronic patient record reviews designed to enable clinicians and managers at any level in the Trust to understand the underlying conditions that lead or contribute to the death of patients and to identify any learning.

This policy relates to all adult deaths, from 18th birthday onwards for which the Trust is responsible (including the Emergency Departments) either by issuing a death certificate or referral to the relevant Coroner.

All child deaths (up to 18th birthday) are reviewed within the processes of the Local Safeguarding Children's Boards (LSCB) through the Child Death Overview Panel (CDOP). However, it would be expected that, where necessary this investigation will be completed as a joint multidisciplinary approach coordinated by the Paediatric department involving any other departments in order to review deaths in older children who may be in the transition between adult and paediatric services (up to their 18th birthday).

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

- Consultants
- Nursing Staff
- Clinical Coding Staff
- Clinical Audit & Effectiveness Staff
- Quality Improvement Staff
- Governance Staff

The policy is applicable to:

- All in-hospital deaths in all specialties

The policy is not applicable to maternity deaths; these are covered by the Trust document "Mortality Review Process WACS" Obs/Gynae/Proc/001 (see Section 6 for link).

3.1 Roles and Responsibilities

Chief Executive

- Has overall responsibility for this policy and compliance

Non-Executive Director

- The Chairperson of the Quality Committee is the Non-Executive Director who will take oversight of progress for the learning form deaths.

Medical Director

- The medical Director is an existing board member acting as the patient safety director to take responsibility for the learning from deaths agenda

Medical Director / Executive Chief Nurse/ Director of Governance

- Responsibility for implementation of the mortality review process
- Responsibility for Mortality Risk on Corporate Risk Register
- Respond to external enquiries about mortality
- Report outcomes and findings from mortality reviews, including LeDeR reviews, to the Trust Board
- Ensure that patient safety recommendations supporting the findings of the reviews are implemented and improvements monitored.

Deputy Medical Directors

- Oversight of the mortality review processes
- Ensuring divisional support for site based mortality review lead clinicians
- Ensuring all deaths are reviewed in all specialties, regardless of site
- Review data provided in relation to Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality indicator (SHMI), and ensure that the Trust is aware at an early stage of any potential areas where outlier alerts may be raised.
- Ensuring that all pertinent cases and findings from mortality case reviews are presented by the appropriate clinical leads at specialty Mortality & Morbidity (M&M) meetings or at clinical audit meetings.
- Triangulating data with Governance and coding team and capture in trust governance system
- Ensuring that outcomes and learning from M&M meetings and clinical audit meetings are recorded and action plans for improvement are developed, where required
- Ensuring that findings are evaluated and reported to specialty and divisional governance meetings to promote learning
- Overseeing progress on the implementation and closure of action plans.
- Where necessary link with the Trusts Coroners liaison officer to identify any requirements from the Coroners officers.
- Develop a site based multi-specialty quarterly report covering a summary of the analysis, lessons learned, good practice points and actions taken; this report will be presented at the Quality Committee.
- Develop reports for Trust Board as required. These reports will also be shared at Clinical Directors group.

Site-Based Mortality Review Lead Clinicians

- The site based mortality review lead clinician arranges a multidisciplinary team, to complete weekly mortality case reviews for all adult deaths and discussion at M&M

meetings.

- Carries out case note reviews as per national and trust agreed standard
- Ensuring data collection, input in system and link to Ulysses system
- Engages with clinical coding when coding issues are identified
- Ensures that patients' families and carers are given an opportunity to be engaged with the review process, including providing feedback on the outcomes of the review as appropriate.
- Ensures all deaths are reviewed using a set proforma as recommended by the National Quality Board (2017) including HOGAN score of 1-5 and an NCEPOD score of 1-5 for each case review – see appendix 1
- Ensure lessons learned are disseminated in the divisional meetings order to obtain the maximum benefit from the reviews.
- Support the development of site based reports showing analysis of the findings from all reviews in order to ensure there is appropriate sharing of learning across the Trust, both good practices as well as identified areas for improvement.
- Liaise with the clinical audit team regarding cases which require discussion at M&M or clinical audit meetings
- Liaise with Divisional Governance Leads in relation to any cases where a full incident investigation is required.
- Liaise with Paediatric department to ensure all paediatric / neonatal deaths are included within the analysis.
- Liaise with Womens and Children's Division (WACS) to ensure all maternal deaths are included in the report
- Work with the site based Deputy Medical Director to develop a site based multi-specialty quarterly report covering a summary of the analysis, lessons learned, good practice points and actions taken; this report will be presented at the Quality Committee.
- Work with the site based Deputy Medical Director to manage the Mortality Risk on the Corporate Risk Register and also develop the annual report for presentation at the Trust Board meeting as a site based multispecialty report

Clinical Directors and Divisional General Managers

- Agree the process for senior attendance at the multidisciplinary, site based mortality review meetings.
- Ensure clinicians are allocated to attend the site based mortality review sessions and job planning is reviewed to ensure this activity is prioritised.
- Ensure that there is learning undertaken from these reviews within the division and where necessary actions are initiated and completed for cases discussed at the M&M or clinical audit meetings.
- WACS Clinical Director to ensure that all maternal deaths are reviewed and reported to the site based Deputy Medical Director for inclusion in the quarterly and annual report
- Paediatrics to ensure that all child deaths are reviewed and reports are completed within the timescale set within the LSCB guidelines for CDOP; provide summary details of all child deaths in the Trust to site based Deputy Medical Director.

Senior Nursing Staff

- Will encourage and lead multi-professional involvement in both conduct of and resulting actions from mortality reviews to promote maximum learning from issues identified.
- Provide professional nursing input / advice at mortality review meetings in conjunction with the medical staff reviewing the case.
- The Clinical Nurse Specialist for Learning Disabilities (trained in LeDeR methodology) is

part of a team of reviewers of deaths of Learning Disability patients for the North West Region. When the LeDeR reviewers cases are identified for full investigation, any lessons learnt will be communicated to the Medical Director.

Bereavement Administration Team

- Compile and update the database of Trust deaths for the Deputy Medical Director, mortality review groups and clinical coding.
- Requesting the patient notes and supply the relevant patient details, including incident and post mortem information, to the site based mortality lead clinicians in preparation for individual case reviews
- Informs Clinical Nurse Specialist (CNS) Learning Disabilities of deaths in those with learning disabilities.
- Informs the lead nurse for safeguarding of any deaths in those with a Deprivation of Liberty in place or who are detained under the Mental Health Act

Clinical Coding

- Participating in mortality peer reviews where coding issues have been identified
- Working with divisions if capture of coding needs improving

Clinical Audit Team

- Identify appropriate cases to be reviewed at clinical audit meetings
- To liaise with bereavement office for release of case notes for clinical audit meetings and subsequent return of said notes back to bereavement office

4. PROCEDURE

The Bereavement Administration Team ensures the relevant patient notes and ensures that the appropriate details including incidents and post mortem information are available to the case note reviewers each week. The Clinical Nurse Specialist for Learning Disabilities is informed of any patient with a learning disability who dies; the CNS instigates the LeDeR review process on behalf of the Trust.

Arranged by the site based mortality review lead clinician, an appropriate multi-disciplinary group should carry out the case reviews alongside the site based mortality lead

Each adult death, including learning disability and mental health cases, will have a case note review and this should be recorded in the Ulysses Bereavement module.

The case note review will establish if there were issues with the organisation of care or delivery of care which could be improved, generating a HOGAN score and an NCEPOD score for each case note review (Appendix 1).

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; clinical coding may take place following the case note review

Case reviews carried out for maternity cases or for children and young people will be added to the Ulysses Bereavement Module by the divisional team. Separate mortality review processes are referred to in section 6.

4.1 Further Investigation

Cases which, when reviewed, generate a HOGAN score of 1 or NCEPOD score of 1 are expected deaths or have no indication of problems with care and are deemed to be unavoidable deaths; no further actions are required

Cases which, when reviewed, generate either a HOGAN score of 2 or NCEPOD score of 2 (or above) require the site based mortality review lead clinician to take further action:

- Where concerns have been identified but no incident has previously been reported, an incident report with brief details should be raised (by the site based mortality review lead clinician to trigger further investigation by the specialty team; the site based Deputy Medical Director should be informed.
- If there are concerns about the standard of care then the case should be reviewed at M&M meetings and clinical audit meetings. The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. The M&M meeting and clinical audit meeting have a central function in supporting services to achieve and maintain high standards of care.
- Discussions, outcomes and learning from the M&M meetings and clinical audit meetings, including conclusions about outstanding care and sub-optimal care, should be formally recorded and reported back to the site based Deputy Medical Director
- Cases should also be discussed at divisional governance meetings with agreed actions being documented for wider learning

Cases which concern patients with learning disabilities will be the subject of additional rigour. The bereavement team will inform the Trust CNS for learning disabilities about the case, and the CNS will then arrange an external LeDeR review which is in addition to the Trust mortality review.

Cases which concern patient detained under the Mental Health Act or who have a DOLS in place will have a Trust mortality review. Additionally, for those who die whilst detained under the Mental Health Act, the safeguarding team will make a mandatory notification to the CQC, which activates robust review by NHS England. The safeguarding team also submits a clinical incident and will notify the Head of Patient Safety in order for the appropriate investigation process to commence.

The records generated from mortality case reviews, discussions at M&M meetings and clinical audit discussions should be used to inform any subsequent investigations, for example complaint or legal claim.

4.2 Outcomes

Outcomes from any investigation that follows the mortality case review (carried out as a result of identifying that there were issues with the organisation of care or where delivery of care could be improved) should be fed back to the patient's family and / or carers as per duty of Candour.

4.3 Reports

A monthly report produced by the Mortality leads will be sent to the Deputy Medical Director and the Divisional triumvirates and their divisional governance business partner for inclusion

in the monthly governance meeting to discuss lessons learnt. A trust wide quarterly report will be provided to the Quality Committee. This report will include data relating to the total numbers deaths in the Trust and information relating to the number of case reviews undertaken and information relating to the number of cases where deaths were more likely than not to have been as a result of problems in care, along with progress on actions taken.

An overall annual report may be provided to the Trust Board from the Deputy Medical Director. The annual report will be a single Trust wide and multispecialty report.

5. ATTACHMENTS	
Number	**Title**
1	HOGAN and NCEPOD scoring
2	Organisational Flow Chart
3	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Obs/Gynae/Proc/001	Mortality Review Process - WACS http://uhmb/cs/tpdl/Documents/OBS-GYNAE-PROC-001.doc
Paed/Guid/001	Bereavement Guideline for Children, Young People and Neonatal http://uhmb/cs/tpdl/Documents/PAED-GUID-001.docx
Corp/Proc/062	Child Death Overview Panel (CDOP) Information Sharing http://uhmb/cs/tpdl/Documents/CORP-PROC-062.docx
Corp/Pol/024	Resuscitation http://uhmb/cs/tpdl/Documents/CORP-POL-024.docx
Corp/Proc/048	Care After Death, Including Last Offices and Legal Documentation http://uhmb/cs/tpdl/Documents/CORP-PROC-048.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	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 Available from: https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability (accessed 11.7.17)
2	National Quality Board (March 2017) National Guidance on Learning from Deaths Available from: https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/ (accessed 11.7.17)
3	Heslop P, Blair P, Fleming P, et al(2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol. Available from: http://www.bristol.ac.uk/cipold/ (accessed 11.7.17)
4	Hogan H et al (2015). Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record review and regression analysis *BMJ*; 351. h3239. Available from: http://www.bmj.com/content/351/bmj.h3239 (accessed 11.7.17)
5	National End of Life Care Programme (2011) When a person dies: guidance for professionals on developing bereavement services. Available from: http://socialwelfare.bl.uk/subject-areas/services-activity/health-services/nhsnationalendoflifecareprogramme/when11.aspx (accessed 11.7.17)
6	Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Available from: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry (accessed 11.7.17)
7	Royal College of Physicians. National Mortality Case Record Review Programme

Bibliography

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
HSMR	Hospital Standardised Mortality Ratio
SHMI	Summary Hospital-level Mortality Indicator
LeDeR	Learning disabilities mortality review programme
HOGAN	An assessment score of preventability
NCEPOD	National Confidential Enquiry into Patient Outcome and Death – assessment of potential for improvement
CQC	Care Quality Commission

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
Mrs Kim Wilson	Assistant Chief Nurse (Patient Safety Unit)	author
Dr Shahedal Bari	Deputy Medical Director (RLI and WGH plus PSU)	06/2017
Dr Paul Grout	Deputy Medical Director (FGH)	07/2017
Mr Brian Evans	Clinical Nurse Specialist (Learning Disabilities)	07/2017
Mr Paul Jebb	Assistant chief Nurse (Mental Health Lead)	08/2017
Mr Mark Lippett	Head of Safeguarding	08/2017
Mrs Sascha Wells	Director of Midwifery, Obstetrics and gynaecology	07/2017
Mrs Paula Evans	Assistant Chief Nurse (Paediatrics)	07/2017
Mrs Sarah Hogg	Bereavement Team	07/2017
Mrs Lynne Kaighan	Clinical Audit Department	07/2017
Mrs Nicky Edmondson	Head of Patient Safety	07/2017

10. DISTRIBUTION PLAN	
Dissemination lead:	Dr Shahedal Bari
Previous document already being used?	No
If yes, in what format and where?	n/a
Proposed action to retrieve out-of-date copies of the document:	n/a
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Friday Corporate Communications Roundup – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this policy? No		
Action by	**Action required**	**Implementation Date**

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.1	20/10/2017	Page 3	BSF page added	01/09/2019

Appendix 1: Hogan and NCEPOD Scoring

Hogan Score - Is there any evidence for preventability of this death?

Score	Definition
1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable but not very likely, less than 50-50 but close call
4	Probably preventable, more than 50-50 but close call
5	Strong evidence for preventability
6	Definitely preventable

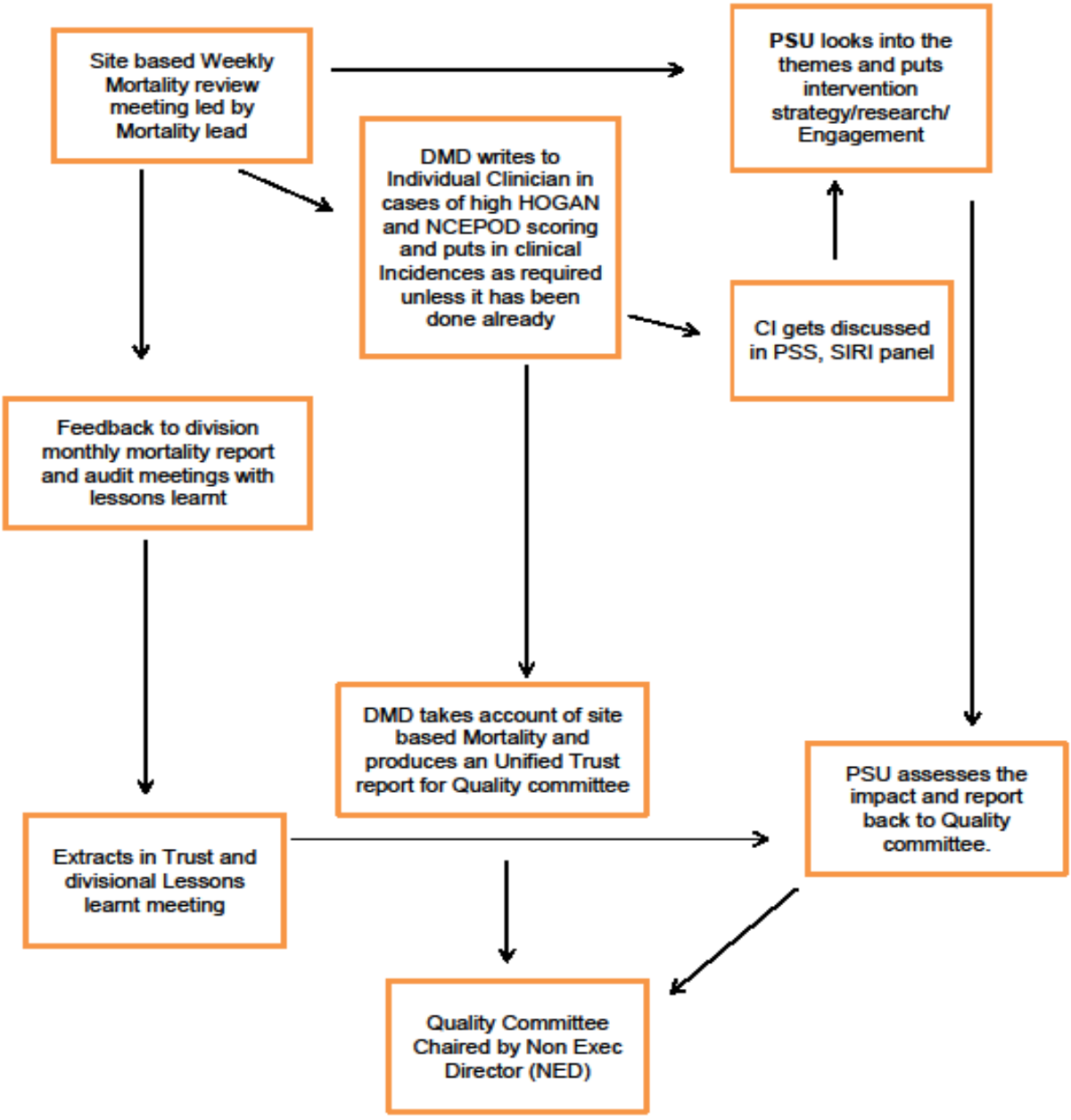
NCEPOD grade – areas for improvement

Score	Definition
1	Good Practice
2	Room for improvement in clinical care
3	Room for improvement in organisational care
4	Room for improvement in clinical and organisational care
5	Less than satisfactory aspects of clinical or organisational care - must be reported as a Clinical Incident via the Safeguard system

Appendix 2: Organisational Flow Chart

University Hospitals of Morecambe Bay NHS Foundation Trust

Mortality Review Flow Chart & Triangulation with Patient Safety Unit UHMB



1 UHMB mortality Review and PSU flow chart SB 2016

Appendix 3: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Patient Safety Unit			
Lead Assessor	Kim Wilson			
What is being assessed?	Mortality Review Process			
Date of assessment	11/07/2017			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☒	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?

Positive:	Negative:	Neutral:
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	Impact (Positive / Negative / Neutral)	Comments ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Positive	Learning disability and mental health deaths must be reviewed
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Positive	Neonatal and child deaths must be reviewed
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Positive	Maternal deaths must be reviewed
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.