Learning from Deaths (Mortality Review) Policy

<table>
<thead>
<tr>
<th>Approval Committee</th>
<th>Version</th>
<th>Issue Date</th>
<th>Review Date</th>
<th>Document Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMB</td>
<td>4</td>
<td>Dec 17</td>
<td>Dec 19</td>
<td>Dr Tiwari, Dr Cranshaw, Joanne Sims</td>
</tr>
</tbody>
</table>

CONSULTATION PROCESS

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Level of Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>June 13</td>
<td>LIPS Team</td>
<td>HAC, PMG, TMB, Mortality Group and Board of Directors</td>
</tr>
<tr>
<td></td>
<td>Sept 14</td>
<td></td>
<td>Mortality Group, MICE Group</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Jan 16</td>
<td>DT/JS</td>
<td>Mortality Group, TMB, QARC</td>
</tr>
<tr>
<td>4</td>
<td>Dec 17</td>
<td>DT/JS</td>
<td>Mortality Group, TMB, QARC</td>
</tr>
</tbody>
</table>
Learning from Deaths (Mortality Review) Policy

1.0 Introduction

1.1 It has become increasingly important for Trusts to provide evidence that they are systematically and continuously reviewing patient outcomes and especially mortality and morbidity.

Learning from deaths that occur within the hospital is an important part of the Trust objective “providing the excellent care we would expect for our families”. Reviewing the care provided to people who have died can help improve care for all patients by identifying problems associated with poor outcomes, and working to understand how and why these occur so that improvement action can be taken.

The board is committed to providing visible and effective leadership to ensure the organisation addresses any significant issues identified in reviews and investigations.

1.2 Under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017, trusts are required to have a learning from deaths policy that should meet the following objectives:

- the processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
- there is an evidence-based approach to undertaking case record reviews
- the trust engages with bereaved families and carers
- staff affected by the deaths of patients are supported.

The National guidance also requires this to be a transparent process where the Board of Directors receive a quarterly report (in the public section of the meeting) on:

- the total number of inpatient deaths
- the number of deaths subjected to formal case record review
- the number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.

This policy sets out the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust approach to meeting these requirements.

2.0 Policy Scope

2.1 This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust’s behalf.
3.0 Purpose

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation’s existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of all inpatient in the care of the Trust.

This policy describes how the Trust will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust’s care. It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read with reference to the Trust Learning Event Report Notification (LERN) Policy, RCA and SI Toolkit and Duty of Candour guidance.

4.0 Definitions

4.1 Mortality

For the purpose of this policy, mortality relates to any in-hospital deaths.

4.2 Mortality Reviews – structured retrospective case record review

A systematic exercise to review case records retrospectively using a structured methodology. The process is used to identify any deficiencies and/or excellence in clinical care and communication. The review is used to draw learning or conclusions to inform any further action that is needed to improve care across the Trust.

4.3 Care Categorisation

It is possible that there might be important learning from a patient’s death even if death was unavoidable.

The care should be categorised using Confidential Enquiry into Stillbirths in Infancy (CESDI). Deaths are classified according to CESDI as follows:

- Grade 0-Unavoidable Death, No Suboptimal Care.
- Grade 1-Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2-Possibly Avoidable Death, Suboptimal care, but different care Might have affected the outcome.
- Grade 3- Probable Avoidable Death, Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome.

Assessment of coding should be part of the case notes review but the primary focus should be to provide assurance on quality of care.
4.4 Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

4.5 Patient Safety Incident

The Trust (and NPSA) definition of a Patient Safety Incident is:

“Any unintended or unexpected incident(s) that could have or did lead to harm for one or more persons receiving NHS funded healthcare”

The Trust Learning Event Notification (LERN) Policy requires all patient safety incidents, including near miss and no harm events, to be recorded on a LERN form and investigated accordingly.

Where a Retrospective case record review identifies that a patient safety incident has occurred (Grades 2-3) then a LERN Form should be completed in accordance with the LERN Policy.

Grade 2 and 3 cases should also be considered as potential serious incidents in line with the Trust Serious Incident (SI) reporting framework.

4.6 Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation’s ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.


4.7 Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

4.8 **End of Life Care**

It may be that after admission, a patient undergoes ‘active’ treatment initially, and later a decision is made to focus on symptom control and dignity (i.e. to provide end of life care). Occasionally, ‘active’ treatment may occur simultaneously with palliative or end of life care. A patient may only be recognised to be dying sometime after the admission. However, this policy is intended to aid learning from any phase of active treatment and end of life care.

Please note if it has been decided that a patient is not for attempted cardiopulmonary resuscitation (i.e. has an AAND form) this does NOT preclude ‘active’ management and does not mean the patient’s death should be assumed to have been unavoidable.

Key questions in the End of Life Section of the case review are:

- ‘In retrospect could it have been identified earlier that patient was dying? (for example avoiding unnecessary or inappropriate tests or treatment in the last days of life, or allowing more time for discussions with the patient or the patient’s family or friends)’
- ‘Were any concerns about the manner of the patient’s death raised?’
- Clear escalation plan or ceiling of treatment documented?

5.0 **Roles and Responsibilities**

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief executive</td>
<td>Overall responsibility for implementing the policy</td>
</tr>
<tr>
<td>Non-executive directors (including the role of a lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda)</td>
<td>Non-executive director responsibilities relating to the framework include:</td>
</tr>
<tr>
<td></td>
<td>• understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny</td>
</tr>
<tr>
<td></td>
<td>• championing quality improvement that leads to actions that improve patient safety</td>
</tr>
<tr>
<td></td>
<td>• assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.</td>
</tr>
<tr>
<td>Medical Director</td>
<td>• Delegated responsibility for implementing the policy and Board level lead for the learning from deaths agenda.</td>
</tr>
<tr>
<td></td>
<td>• The Medical Director is chair of the Trust Mortality Surveillance Group</td>
</tr>
<tr>
<td>Trust Mortality lead</td>
<td>• Consultant lead for the Trust Mortality agenda. Responsible to the Medical Director</td>
</tr>
</tbody>
</table>
### Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability lead</td>
<td>• Act as trained LeDeR Learning Disability Mortality Reviewer</td>
</tr>
<tr>
<td>Other specific roles</td>
<td>See below</td>
</tr>
<tr>
<td>All staff</td>
<td>See below</td>
</tr>
</tbody>
</table>

**Clinical Directors** are responsible for:

- Ensuring that there is a formal M&M meeting for all specialties within their Directorates
- Establishing reporting processes from M&Ms to the Directorate/Care Group Clinical Governance Group.
- Ensuring that issues, trends and actions are routinely reported to the Directorate/Care Group Clinical Governance Group as a standing agenda item.
- Ensuring that significant risk issues arising from Mortality Reviews are raised at the Trust Mortality Surveillance Group, QARC as appropriate.
- Ensuring that significant risk issues arising from Mortality Reviews are raised at TMB if required.
- Ensuring that Grade 2 and 3 cases are reported and investigated in accordance with the Trust LERN and SI policy.

**Chairs of Directorate/Specialty Mortality Meetings**

Clinical Directors will ensure that Mortality and Morbidity (M&M) Chairs are nominated and appropriately job planned within the directorate. In some cases the M&M chair will cover the whole directorate, in other cases speciality level leads have been appointed.

The M&M Chair is responsible for ensuring:

- The facilitation of case note reviews (using the standard eMortality Review proforma) of all deceased inpatients as triggered by notification from the eMortality electronic system
- All inpatient deaths are reviewed and documented using the eMortality Review proforma.
- All reviews are completed electronically and saved to the central database
- All deaths are discussed at the speciality M&M meeting and key learning points and action plans agreed and documented.
- Cross speciality advice is sought as appropriate to the mortality review e.g. ITU, palliative care, radiology
- The findings and action plans of the speciality M&M meeting are reported into the Directorate/Care Group Clinical Governance Group
- Significant trends, concerns or risk issues from mortality reviews are reported to the Trust Mortality Surveillance Group as appropriate
- Significant risk issues are flagged to the directorate Quality and Risk Lead and Clinical Director for reporting to QARC and/or TMB.
- Escalation of any specific areas of significant concern e.g. serious incidents identified from a review, using other Trust policies where appropriate.
- Ensure 2-3 grade cases are reported as LERNs.
Medical Staff

- All consultant medical staff should participate in the M&M process for any patients under their responsibility.
- All consultants undertaking mortality reviews are responsible for contacting clinicians in other specialities where relevant to the patients admission and care. E.g. ITU, palliative care, radiology.
- All medical staff should participate in all M&M reviews that are relevant to their practice.
- All junior doctors should be actively encouraged to participate in Mortality reviews, case presentations and M&M meetings.

Nurses, Allied Health Professionals and Other Clinical Staff

All relevant healthcare professionals should be involved in learning from M&M reviews. Feedback may be on an individual case review or via key learning points and/or trends discussed and/or cascaded via relevant Trust or directorate/Care Group clinical governance meetings, team meetings or other similar forum.

6.0 Governance Structures

<table>
<thead>
<tr>
<th>Committee</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Board</td>
<td>The Board of Directors are responsible for meeting the requirements (Annex A and B of the National Guidance on Learning from Deaths. See Appendix 1. The Board are responsible for reviewing the quarterly report provided by the Mortality Surveillance Group (in accordance with National requirements).</td>
</tr>
<tr>
<td>Mortality Surveillance Group</td>
<td>See Appendix 2</td>
</tr>
<tr>
<td>Healthcare Assurance Committee</td>
<td>To receive a quarterly report from the Mortality Surveillance Group</td>
</tr>
<tr>
<td>Quality and Risk Committee</td>
<td>To receive reports from directorate governance meetings and review any learning from mortality reviews.</td>
</tr>
<tr>
<td>Mortality Meetings (Directorate/Specialty)</td>
<td>See below</td>
</tr>
</tbody>
</table>
**Mortality and Morbidity (M&M) Meeting**

Mortality (or M&M) meetings must be held for all named clinical specialities listed in Appendix 3. Meetings may also be held in other specialities such as critical care and Interventional Radiology. M&M chairs may also be asked to contribute to reviews overseen by another speciality.

The Trust policy is to ensure:
- There is consistency of approach to the review of inpatient mortality throughout the Trust via the use of a standardised proforma (Retrospective Case Record Review).
- The outputs of any mortality reviews are clearly documented, action plans agreed and learning points disseminated.
- Feedback from Mortality meetings is routinely discussed at the Mortality Surveillance Group.
- Feedback from Mortality meetings is routinely discussed at the Directorate Clinical Governance Group or similar named forum.

Each Speciality M&M meeting should have the following minimum standards:
- A nominated (identified) Chair
- At least quarterly meetings
- Multi-disciplinary and multi-professional membership
- All death reviews must be recorded via the Trust electronic Mortality Review Proforma
- Any learning points and actions from each meeting are recorded and cascaded in accordance with the governance arrangements shown in Appendix 3.
- All grade 2 and 3 deaths are reported immediately as a LERN

Meetings should comprise a multi-disciplinary group reviewing and discussing clinical cases in relation to clinical care, complications and/or death; ideally and where possible, in the context of existing outcome data and related information (e.g. complaints, Dr Foster reports or other benchmarks or standards). A specific requirement of the Francis Report (2013) is that M&M meetings should include senior and junior doctors, nurses and other Allied Health Professionals as appropriate for that speciality.

The Chair of the meeting should ensure that there is a process for ensuring any findings are shared and that any actions are suitably recorded, co-ordinated and cascaded throughout the speciality.

A standard M&M meeting template is available via the e-Mortality process.

**7.0 The process for recording deaths in care**

For additional details refer to the following:

- Care After Death Policy (previously known as the last offices policy)
  [http://rbhintranet/policies/nursing/Care-After-Death-Policy.pdf](http://rbhintranet/policies/nursing/Care-After-Death-Policy.pdf)


• Policy for the Deactivation of Implantable Cardioverter Defibrillators (ICD) towards the end of life and following death

• ED Child death/anticipated death process for all 0-18yrs

• Procedure for the death of a patient in the Bournemouth Transplant Unit follows ASCT – autologous stem cell transplantation

The next of kin will be informed of the death as soon as possible after the verification/certification. Where there is no next of kin, the police should be informed immediately. If there is any difficulty in contacting the next of kin, the police may be able to assist in locating them and asking them to contact the hospital.

The next of kin/carer should be advised to collect the “cause of death” certificate and property from the general office during office hours. They will be asked to phone General Office, after 10am, in order to confirm that all property, and documentation are ready for collection. Cause of Death certificates CANNOT be collected out of hours, at weekends or Bank Holidays. Advice can be sought from the General Office or the Site Manager [out of hours].

All deaths must be entered on ECamis within 30 minutes of the event.

The cause of death certificate, deceased patient’s notes and property should be completed in the General Office at Bournemouth [unless the patient is on the Macmillan Unit at Christchurch Hospital]. The Macmillan Unit patients have the documentation completed on the Macmillan Unit but the notes are sent to General Office at Bournemouth.

DEATHS CAN ONLY BE CERTIFIED BY A REGISTERED MEDICAL PRACTITIONER

Medical staff must complete an eIDF for all deaths.

8. Selecting deaths for case record review
The Trust will undertake a retrospective case record review for ALL inpatient deaths.

This will include undertaking reviews to meet all of the specific categories of deaths mandated in the Learning from Deaths framework and all categories listed in the National Guidance on Learning from Deaths)

The Trust (via the Mortality Surveillance Group) will continuously monitor SHMI to review mortality ratios of deaths within 30 days of discharge. A themed review will be commissioned by MSG if any upward trend is noted.

As required the Trust will respond to requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death.

The Trust will forward details of any Learning Disability deaths to the LeDER programme.
9. Review methodology

The Trust has developed a standard eMortality/ Retrospective Case Record Review Form

All sections of the eMortality Review Form should be completed for all inpatient deaths.

<table>
<thead>
<tr>
<th>Patient group</th>
<th>Methodology</th>
<th>Reviewer</th>
<th>Timescale for review</th>
<th>Where info/output will be saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult inpatient</td>
<td>Structured case note review by lead, presentation to speciality/directorate Mortality meeting for Peer review and agreement on grading, actions and learning points</td>
<td>Lead consultant</td>
<td>60 days for consultant review</td>
<td>e-Mortality</td>
</tr>
<tr>
<td>Learning disability</td>
<td>The Trust will adopt the LeDeR method to review the care of individuals with learning disabilities. CPI flags and coding will be used to flag patients with learning disabilities so their care can be reviewed.</td>
<td>Lead consultant (internal review) CCG appointed National LeDER programme investigator (external review)</td>
<td>60 days for internal consultant review</td>
<td>e-Mortality</td>
</tr>
<tr>
<td>Child (under 18)</td>
<td>Reviews of these deaths are mandatory and will be undertaken in accordance with Working together to safeguard children ¹ (2015) and the current child death overview panel processes.</td>
<td>Safeguarding lead for Children</td>
<td>60 days for consultant review</td>
<td>e-Mortality and SI Process (Datix)</td>
</tr>
<tr>
<td>Perinatal and maternity</td>
<td>All perinatal deaths will be reviewed, using the new perinatal mortality review tool² once available. Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and if applicable will be investigated accordingly</td>
<td>Lead investigator National inquiry in to maternal death.</td>
<td>60 days for internal review</td>
<td>e-Mortality and SI Process (Datix)</td>
</tr>
</tbody>
</table>

All eMortality reviews of in-hospital deaths are expected to be completed by the lead consultant within 60 days of patient’s death. Review at a relevant M&M meeting should be within 3-4 months.

² https://www.npeu.ox.ac.uk/pmrt
10. Staff training and support

10.1 Training on the Death Certification process is covered on Junior Doctors induction and core teaching programme.

10.2 1:1 training on use of the e-Mortality system is provided by the IT Training Department.

10.3 The Trust Mortality lead and the Associate Director for Quality and Risk have received Royal College of Physicians (RCP) Structured Case Record (SCR) Training and will lead of any cascade of training as appropriate.

10.4 The Quality and Risk Department provide regular Root Cause Analysis (RCA) training. Sessions cover processes applicable to grade 2 and 3 mortality review investigations. Sessions can be booked via ESR and BEAT.

10.5 The Trust has trained a number of senior leads (including the Medical Director, Associate Medical Director, Clinical Directors for Surgery, ED and cardiology, Head of Midwifery, Heads of Nursing and Quality and the Associate Director for Quality and Risk) to chair Serious Incident investigation panels.

11. Selecting deaths for investigation

11.1 Where a Retrospective case record review identifies that a patient safety incident has occurred (Grades 2-3) then a LERN Form should be completed in accordance with the LERN Policy.

11.2 Grade 2 and 3 cases should also be considered as potential serious incidents in line with the Trust Serious Incident (SI) reporting framework.

12. Reviewing outputs from review and investigation to inform quality improvement

12.1 The findings of mortality reviews and investigations will be used to inform quality improvement work across the Trust and support the Trust Quality priorities as set out in the Quality Account and Quality Strategy.

12.2 Additional actions include:

- Feedback from Mortality leads to the Mortality Surveillance Group and publication of a quarterly mortality newsletter to share key learning points for Trust wide dissemination
- Feedback from Directorate Governance leads to the Quality and Risk Committee and inclusion of any learning points for Trust wide action and/or dissemination in the QARC Top 10
- Shared learning with any linked Quality Improvement or Clinical Audit work/activity within the Trust e.g. via the Annual Patient Safety and Quality Improvement Conference case study presentation and/or poster
- Sharing learning as part of the Wessex AHSN
- Sharing learning via the Dorset and WH CCG Patient Safety Networks
- Quarterly reporting on learning from mortality reviews to the public part of the Board of Directors meeting
- Receiving and discussing findings from any national audit programmes at MSG and dissemination via meeting papers to mortality leads.
13. Presenting relevant information in board reports

13.1 The Mortality Surveillance Group will provide a quarterly report to part 1 (public part) of the Board of Directors summarising the details of the number of structured mortality case note reviews completed and the gradings recorded.

13.2 The Mortality Surveillance Group will provide a quarterly report to HAC summarising the details of meetings held, compliance with the eMortality review process and findings of reviews carried out and actions taken as a result of lessons learnt.

13.4 Directorates will be responsible for providing assurance on implementation of the Mortality Review process as part of Directorate/Care Group governance meetings.

13.5 A standard suite of e Mortality system reports will be used to support monitoring by specialities and relevant groups and committees.

14. Supporting and involving families and carers

14.1 The Trust will ensure the following key principles are met during the mortality review process:

- bereaved families and carers are treated as equal partners following a bereavement;
- bereaved families and carers will always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- bereaved families and carers receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.
- bereaved families and carers are informed of their right to raise concerns about the quality of care provided to their loved one;
- bereaved families’ and carers’ views are used to inform decisions about whether a detailed serious incident investigation is needed;
- bereaved families and carers receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;

14.2 All bereaved families will be provided with written information (via the Trust Bereavement patient information leaflet) informing them that all deaths are reviewed and asking them if they have any questions or concerns about the death of their relative.

14.3 At all appropriate stages, families should also be asked what feedback they might want following the review and any specific questions or concerns they would like answered.


15. Supporting and involving staff

15.1 Staff affected by the death of patients are able to seek support from:

- Line manager
- Clinical and/or Educational Supervisor
- Occupational Health
- Chaplaincy
• Quality and Risk Team
• Union representative i.e. RCN, Unison

15.2 The Trust Employee Assistance Programme (EAP) is provided by Care First.

Care First, is a complete workplace support service. The services are available online, and via a Freephone number 24Hrs a day 365 days of the year. Access to information, counselling, emotional support and wellbeing is free for all employees. It is completely confidential.

The free EAP phone service, is 0800 174319 number from a landline, or #685 as the Trust shortcut.

Full details of the service are available on the Health and Well Being pages of the intranet. http://rbhintranet/page.php?link=eap

15.3 Other sources of information or support include:
https://www.cruse.org.uk/
https://www.themdu.com/
https://www.nmc.org.uk/

15.4 All mortality reviews following the Trust SI process will record (as part of the scoping meeting and final panel report) that staff support has been provided appropriately.

16.0 Document Control, Archiving and Review of this Policy

16.1 Document Control
The policy will be updated and reviewed in accordance with the Trust Document Control Policy.

16.2 Archiving
The Policy will be stored on the Trust’s Intranet as a live version. Once updated an archive copy will be stored on the Trust Document Management System in accordance with the Trust Document Control Policy.

16.3 Review
The policy will be reviewed two yearly by the Mortality Surveillance Group.
Appendix 1 - National Guidance on Learning from Deaths, Annex A and B - Board Leadership and the role of Non-Executive Directors

Board of Directors

The board should ensure that their organisation:

- has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress;
- pays particular attention to the care of patients with a learning disability or mental health needs;
- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts;
- shares relevant learning across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;
- acknowledges that an independent investigation may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation;
- work with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

Non-Executive Directors

All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy.
Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider’s management in meeting agreed goals and objectives and monitor the reporting of performance.

Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

The roles and responsibilities of non-executive directors include:

- **Understanding the process:** ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:
  - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust?
  - seek similar data and trend information from peer providers, to help challenge potential for improvements, but understand limitations of any direct comparisons;
  - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer and quality of the review or investigation;
  - consider whether the Care Record Review process is objective, conducted by clinicians not directly involved in the care of the deceased?
  - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
  - consider the governance and coordination of responses to reviews/investigations who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

- **Champion and support learning and quality improvement such as:**
  - ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
  - understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
  - understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
  - supporting any changes in clinical practice that are needed to improve care resulting from this learning;
  - ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
  - paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

- **Assure published information:** ensure that information published is a fair and accurate reflection of the achievements and challenges, such as:
  - ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
  - checking timely quarterly publication, in line with the Quality Accounts regulations and guidance;
  - checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
  - ensuring the organisation can demonstrate to stakeholders that “this is what we said we would do, and this is what we did” (learning and action), and explain the impact of the quality improvement actions.
Appendix 2

MORTALITY SURVEILLANCE GROUP MEETING

TERMS OF REFERENCE

The Mortality Group Meeting “The Group” is a working group established by and responsible to the Healthcare Assurance Committee.

The Group serves to ensure that there is an effective framework within which assurances can be given across the following areas of business.

1. **Membership**

   1.1 The Committee Chairman (the “Chairman”) shall be the Medical Director. In the absence of the Chairman the Deputy Chair shall be the Clinical Lead for Mortality. In the absence of both the Chair and Deputy Chair the Associate Director of Service Development will act as Chair.

   1.2 Standing members of the Committee shall include Medical Director; Non-Executive Director; Associate Director of Service Development; Associate Director - Clinical Governance; Clinical Lead for Mortality; Senior Information Analyst; Clinical Effectiveness Manager; Service Development & Coding Manager; Deputy Director of Nursing, Head of Nursing & Quality; Claims and Inquest Manager; Public Governor and M&M leads for specialties across Trust. See Appendix 2

   1.3 Invited members for specific issues would include Director of Service Development; General Office Manager and Senior Analyst from Dr Foster Intelligence.

   1.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate.

   1.5 It is expected that members attend a minimum of 8 meetings per year and nominate a deputy for the occasions they cannot attend unless agreed otherwise.

2. **Secretary**

   The PA to the Medical Director (the “Secretary”) or their nominee shall act as the secretary of the Committee.

3. **Quorum**

   The quorum necessary for the transaction of business shall be 4 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4. **Frequency of Meetings**

   The Committee shall meet monthly.

5. **Notice of Meetings**
5.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

6. Minutes of Meetings

6.1 The Secretary shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.

6.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Internal Control, Risk Management & Assurance

7.1.1 To review monthly death certification reports and compare with e-IDF primary diagnosis coding to ensure accuracy of coding by exception.

7.1.2 To review Dr Foster CUSUM or relative risk reports monthly for HSMR, SHMI and high risk conditions, and highlight areas for specific coding and clinical review. To review e-mortality and extract data for the overall completion rate, categorization of death, avoidable mortality and mortality in learning disability.

7.1.3 To highlight potential areas of risk to the Healthcare Assurance Committee.

7.1.4 To identify any potential actual or potential Dr Foster or Care Quality Commission Alerts and to make recommendations for action to Healthcare Assurance and Board of Directors as required.

7.1.5 To review any coding procedures that may influence the Trusts CUSUM or relative risk results and recommends any action as necessary to ensure data accuracy.

7.1.6 To receive reports from all the specialty M&M or governance meetings and discuss cases relating to death following intervention/procedure or unexpected deaths and disseminate learning across the Trust.

7.1.7 To review the Trusts overall Standardised Mortality Ratio (monthly) and review specialty mortality rates (by top HRG groups) on a rolling programme.

7.2 External Validation & Assessment

7.2.1 To review any submissions to external agencies where the report may affect the Trusts reputation, position or quality ratings on patient safety, mortality or quality of care performance.

7.3 Annual Reports and Plans
7.3.1 To provide a quarterly report to the (as part of the Quality Account) Healthcare Assurance Committee on reviews completed and actions taken to improve data quality and hospital standardised mortality rates.

7.4 National Guidance and Policy

7.4.1 To identify any training requirements in relation to the use, analysis and investigation of Dr Foster and CQC Mortality Data and reports and e-mortality review.

8. Reporting Responsibilities

8.1 The Medical Director shall report quarterly to the public part of Board of Directors meeting. This should include numbers of mortality metrics, numbers of deaths, and numbers of deaths reviewed by month and those that have been graded as having avoidable features and mortality in learning disability.

8.2 The Committee shall report quarterly to the Healthcare Assurance Committee. A report shall be presented by the Medical Director.

9. Other

The Committee shall:

9.1 Give due consideration to laws and regulations and the provisions of the Code of Governance.

9.2 Oversee any investigation of activities which are within its terms of reference.

9.3 At least once a year review terms of reference and attendance to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Healthcare Assurance Committee for approval.

10. Authority

The Committee is authorised:

10.1 To seek any information it requires from any employee of the Trust in order to perform its duties.

10.2 To obtain, at the Trust’s expense, outside legal or other professional advice on any matter within its Terms of Reference.
**APPENDIX 1 – Directorate Clinical Governance Key Performance Indicators**

### Regular Reports Received by Mortality Surveillance Group

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Frequency of Report</th>
<th>Reported by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Foster HSMR reports (CUSUM, Relative Risk), crude mortality rates, deaths within 36 hours of admission, deaths in high risk groups. E-mortality reviews.</td>
<td>Monthly</td>
<td>Trust Clinical Lead for Mortality and Senior Information Analyst</td>
</tr>
<tr>
<td>Dr Foster Intelligence Report</td>
<td>Quarterly</td>
<td>Dr Foster Information Analyst</td>
</tr>
<tr>
<td>CQC Mortality Alerts</td>
<td>As Alerts Arise</td>
<td>Clinical Effectiveness Manager and Trust Clinical Lead for the Mortality</td>
</tr>
<tr>
<td>CQC Insight Report</td>
<td>Monthly</td>
<td>Associate Director for Governance</td>
</tr>
<tr>
<td>Coding quality reports</td>
<td>By exception</td>
<td>Coding Manager</td>
</tr>
<tr>
<td>Quarterly reports from speciality M&amp;M meetings</td>
<td>Quarterly</td>
<td>Coding Manager</td>
</tr>
</tbody>
</table>

### Regular Reports Provided to Healthcare Assurance Committee

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Frequency of Report</th>
<th>Provided by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress on review of CQC Mortality reports and reviews</td>
<td>Quarterly</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Significant risks raised following review of Dr Foster data</td>
<td>Quarterly</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

### Regular Reports Provided to Board of Directors

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Frequency of Report</th>
<th>Provided by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress on review of CQC Mortality reports and reviews</td>
<td>Quarterly</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Mortality matrix, mortality review completion rate, avoidable mortality,</td>
<td>Quarterly</td>
<td>Medical Director</td>
</tr>
<tr>
<td>mortality in learning disability, key learning themes from mortality reviews.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX 2 M&M Leads

<table>
<thead>
<tr>
<th>M&amp;M Chairs Speciality / Department / Directorate</th>
<th>M&amp;M Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Safa Al-Shamma</td>
</tr>
<tr>
<td>Diabetes &amp; Endocrine</td>
<td>Georgina Page (Quarterly)</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Jehangir Din</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Dawn Edwards</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Abbey Banfield</td>
</tr>
<tr>
<td>Older People’s Medicine</td>
<td>Sue Hazel</td>
</tr>
<tr>
<td>Stroke</td>
<td>Kamy Thavanesan</td>
</tr>
<tr>
<td>ED</td>
<td>Matthew Baker (Quarterly)</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Richard Hartley</td>
</tr>
<tr>
<td>Vascular</td>
<td>John Oakes</td>
</tr>
<tr>
<td>Surgery</td>
<td>Nick Baylem</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Catherine Marsh (on invitation)</td>
</tr>
<tr>
<td>Haematology</td>
<td>Helen McCarthy (Quarterly)</td>
</tr>
<tr>
<td>Urology</td>
<td>Joshua Phillips</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Lynsey Woodward</td>
</tr>
<tr>
<td>ITU</td>
<td>Jules Cranshaw</td>
</tr>
<tr>
<td>Radiology</td>
<td>David Beckett (Quarterly)</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>Helen Whalley</td>
</tr>
</tbody>
</table>
Appendix 4 – MORTALITY REVIEW eFORM

Please remember to click the sign off button at the bottom of the form

### Mortality Review

| Patient Name |  |
| Hospital Number | Sex |
| D.O.B (dd/mm/yyyy) | Age |

### Section 1

<table>
<thead>
<tr>
<th>Date of review</th>
<th>Discharging Consultant / Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting Consultant</td>
<td></td>
</tr>
<tr>
<td>Speciality</td>
<td>Directorate</td>
</tr>
<tr>
<td>Date of admission</td>
<td>Time of admission</td>
</tr>
<tr>
<td>Date of death</td>
<td>Time of death</td>
</tr>
<tr>
<td>Day of the week admitted</td>
<td>Day of the week died</td>
</tr>
</tbody>
</table>

Main diagnosis on admission

Cause of death on death certificate

1a

1b

1c

Part 2

Type of referral

The whole eForm needs to be completed

Category of care during inpatient stay (please mark all applicable)

| Medical | ED | AMU | Surgical | CCU | ITU | Haem/Onc | Other |

Was the patients’ care supported by Personalised Care Plan for last days of life?

Yes ✔ No
<table>
<thead>
<tr>
<th>Discussion documented with patient and or family and friends?</th>
<th>Yes [ ] No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were any concerns about the manner of patients' death raised?</td>
<td>Yes [ ] No [ ]</td>
</tr>
<tr>
<td>For example: Futile active management / inappropriate ward moves / Things you would not want for your family / nutrition and fluid management.</td>
<td>If yes please Specify</td>
</tr>
<tr>
<td>Clear escalation plan or ceiling of care documented?</td>
<td>Yes [ ] No [ ]</td>
</tr>
<tr>
<td>In retrospect could it have been identified earlier that the patient was dying?</td>
<td>Definitely [ ] Possibly [ ] Definitely Not [ ]</td>
</tr>
<tr>
<td>If Definitely or Possibly please give details:</td>
<td></td>
</tr>
<tr>
<td>Patients' allow a natural death status documented?</td>
<td>Yes [x] No [ ]</td>
</tr>
<tr>
<td>Was this hospital the most appropriate place for this patient to die?</td>
<td>Yes [x] No [ ]</td>
</tr>
</tbody>
</table>
### Section 2

- **Grade 0** - Unavoidable death, no suboptimal care.
- **Grade 1** - Unavoidable death, suboptimal care, but different management would not have made difference to the outcome.
- **Grade 2** - Possibly avoidable death. Suboptimal care, but different care MIGHT have affected the outcome.
- **Grade 3** - Probable avoidable death. Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome.

Please categorise the care during patients in hospital stay, tick as appropriate.

<table>
<thead>
<tr>
<th>Grade 0</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
</tr>
</thead>
</table>

Please explain:

### Section 3

On reviewing the whole case in your opinion was there evidence of any delays in:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escalation of treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If **yes** please specify:

Were there any areas of poor communication?

If **yes** please specify:

Was fluid / electrolyte management and nutrition assessment appropriate?

If **no** please specify:

Was there appropriate VTE assessment and management?

On reviewing the whole case, in your opinion was there any failure to recognise or take appropriate action on alerts e.g. NEWS?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to recognise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to communicate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was an arrest call put out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to monitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Did these contribute to death?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were there any medication errors including missed doses?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Evidence of timely and appropriate senior review?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is documentation inadequate to classify any sections of this mortality review?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sepsis**

- Did the patient die of sepsis or sepsis related cause? Yes ✔ No □
- Was high flow oxygen administered appropriately within the first hour? Yes [ ] No [ ] NA [ ]
- Were blood cultures taken in the first hour? Yes [ ] No [ ] NA [ ]
- Were antibiotics given in the first hour? Yes [ ] No [ ] NA [ ]
- Were appropriate IV fluids given? Yes [ ] No [ ] NA [ ]
- Was serum lactate measured? Yes [ ] No [ ] NA [ ]
- Was urine output appropriately measured? Yes [ ] No [ ] NA [ ]
### Section 4

**What were the learning points?**

**Suggested recommendations/actions:**

---

### ITU Comments

ITU Review Section - Please type your comment below and click "Add comment"

nb. - To cut and paste from another program - please use CONTROL+C (to COPY) and CONTROL+V (to paste)

---

### ITU Review

ITU Reviewed by

ITU Reviewed by Date

ITU Sign Off

---

**This section is to be completed during the M&M Chair Meeting**

To Action

---

### Section 5

Reviewed by

Date

Mortality Review Chair Name

Date

Reviewer Sign Off

Chair Sign Off

To be reviewed by another speciality

Please state who should see the eform

---

file:///C:/Users/admin.RBCH/AppData/Roaming/ImageNow/worksheets/14/Mortality... 23/03/2016
# EQUALITY IMPACT ASSESSMENT – SCREENING FORM

| 1. Title of document/service for assessment | Mortality Review Policy |
| 2. Date of assessment | 21/9/14 |
| 3. Date for review | 21/9/16 |
| 4. Directorate/Service | Risk Management |
| 5. Approval Committee | Mortality Group/MICE/TMB |

<table>
<thead>
<tr>
<th>6. Does the document/service affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender (including transgender)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation, to include heterosexual, lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

| 7. Does this document affect an individual’s human rights? | No |

| 8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified? | No |

<table>
<thead>
<tr>
<th>9. If the answers to any of the above questions is ‘yes’ then:</th>
<th>Tick</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate that such a disadvantage or advantage can be justified or is valid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjust the policy to remove disadvantage identified or better promote equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If neither of the above possible, submit to Diversity Committee for review.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 10. Screener(s) | Joanne Sims |

| 11. Date Policy approved by Committee | Sept 14 |

| 12. Upon completion of the screening and approval by Committee, this document should be uploaded to papertrail. | |

V4 Oct 17