Yeovil District Hospital NHS
NHS Foundation Trust

LEARNING FROM DEATHS
MORTALITY REVIEW POLICY

Version	1.4	Version Date	July 2021
Policy Owner	Chief Medical Officer		
Author	Learning from Deaths Manager		
First approval or date last reviewed	July 2017		
Staff/Groups Consulted	Deputy Director, Quality Governance and Patient Safety Chief Medical Officer Medical Examiners Clinical Directors, Patient Safety and Governance Mortality Review Group Clinical Outcomes Committee Clinical Directors all specialties Risk and Litigation Lead Non-executive Director		
Draft agreed by Policy Owner	September 2021		
Approved by Clinical Outcomes Committee	October 2021		
Next Review Date	September 2024		
Policy Audited			
Equality Impact Assessment Completed	Yes		

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1. BACKGROUND

1.1 Learning from Deaths. The Care Quality Commission's review into Southern Health NHS Foundation Trust, Learning, candour and accountability, emphasised the importance of providers putting in place robust arrangements to identify, report, review, investigate and learn from deaths of patients under their care. NHS Trusts and Foundation Trusts are specifically obliged to comply with the detailed guidance which the National Quality Board has subsequently published (National Guidance on Learning from Deaths, available at https://www.england.nhs.uk/publication/national-guidance-on-learning-fromdeaths/).

1.2 Concern about patient safety and scrutiny of mortality rates has led to an increased drive for Trust Boards to be assured that deaths are reviewed. This ensures that appropriate changes are made to ensure patients are safe in line with the National Guidance on Learning from Deaths (March, 2017).

1.3 The Care Quality Commission's publication in December 2016 - 'Learning, Candour and Accountability' : A review of the way NHS Trusts review and investigate the deaths of patients in England, builds on the need to maximise learning from deaths. As does the Guidance for NHS Trusts on working with bereaved families and carers. NHS England for National Quality Board (2018)

1.4 Effective clinical audit and review processes incorporating analysis of mortality and morbidity contribute to improved patient safety. The specialty Mortality & Morbidity (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.

1.5 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.

1.6 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.

1.7 A standardised trust-wide process using an electronic version of the Structured Judgement Review Tool (SJR), developed by the Royal College of Physicians and adopted nationally, enables integration of learning into the governance framework. This provides greater levels of assurance to the Trust Board and helps 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.

2. PURPOSE

2.1 The policy has been written to provide guidance for all staff involved in mortality reviews including clinicians, clinical coding, governance, performance analysts, end- of-life and palliative care, and clinical audit and effectiveness staff.

2.2 The aim of the mortality review process is to:

- Identify and minimise 'preventable' deaths in all Trust hospital sites
- Review the quality of end of life care
- Ensure 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
- Enable informed reporting with a transparent methodology
- Promote organisational learning and improvement

3. DEFINITIONS

3.1 Mortality Rate

The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

3.2 Mortality Review Process

A structured methodology for retrospective case note review following a patient's death to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

3.3 Hospital Standardised Mortality Ratio (HSMR)

The Trust uses Mortality data from Dr Foster Intelligence. The organisation provides external assurance, providing a monthly analytical review of outcomes data in respect of Mortality within the Trust. This includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators, comparing the number of expected deaths with the actual number of deaths allowing a greater understanding of quality and improvements in clinical care.

3.4 CUSUM Alert

Where the number of actual deaths exceeds the number of expected deaths a CUSUM alert is generated - CUSUM is short for cumulative sum and an alert occurs when the number of deaths, readmissions or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated.

3.5 Serious Incidents

Adverse events that can result in harm to the patient including severe harm and death that require investigation using Level 1 (Concise) and Level 2 (Comprehensive) Root Cause Analysis and associated methodologies. In line with national guidance and local policies.

3.6 Intrauterine Deaths, Stillbirths, Neonatal and Maternal Deaths

Deaths that require investigation in accordance with national guidance using predefined methodologies, Perinatal Mortality Review tools (PMRT) and reporting systems such as Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), and investigating concerns through the Healthcare Safety Investigation Branch (HSIB) and Child Death Review Panels.

3.7 Learning Disability Mortality Review Programme (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.

4. SCOPE

4.1 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
- Performance Analysts
- Quality Improvement and Patient Safety Staff
- Governance Staff

4.2 The mortality review process is applicable to:

- All in-hospital deaths in all specialties, in particular cases referred by the Medical Examiner or HM Coroner or where a significant incident has been raised.
- Diagnosis groups where outliers have been identified by Dr Foster
- Diagnosis groups identified by the Mortality Review Committee

4.3 The mortality review process forms one aspect of the Trust's quality improvement work. The aim is that all in-hospital deaths will be reviewed at an appropriate level using the Structured Judgement Review Tool or associated methodologies (RCA, Perinatal Mortality Review Tool)

4.4 The Maternity Risk Manager will ensure all mortality reviews for all Intrauterine Deaths, Stillbirths, Neonatal and Maternal Deaths are completed and are aligned to the reporting processes of this policy.

4.5 All deaths of a patient with a Learning Disability will be logged with the National LeDeR notification system. The LeDeR programme provides an opportunity for peer review of all Learning Disability deaths. The learning from these is co-ordinated and shared via the County Wide LeDeR Steering Group, with representatives on the Steering Group providing shared learning to the Incident, investigation and Learning Group. All deaths of inpatients with a Learning Disability will be subject to rapid review using the structured Judgement template to identify any immediate actions required.

4.6 The Child Death Overview Panel reviews all child deaths. Notification of a child death to the Local Safeguarding Children Board is made at the time of any agency becoming aware of the following:

- a child death occurring in Somerset
- a death of a normally resident Somerset child occurring elsewhere

Notification is made using the Form A – Notification of a Child Death and sending this to the Child Death Administrator from the Somerset Safeguarding Children Board. This is usually undertaken by the Paediatrician managing the case.

5. ROLES AND RESPONSIBILITIES

5.1 The overall responsibility for the mortality review process sits with the Chief Medical Officer who will ensure that outcomes and findings are coordinated through the Mortality Review Group and reported quarterly to the Clinical Outcomes and Governance Assurance Committees and to the Trust Board.

5.2 Chief Medical Officer

The Chief Medical Officer will be responsible for:

- Overall oversight and regular review of the mortality review process
- Identifying with the Learning from Deaths Manager, the relevant Clinical Director to ensure completion of the individual mortality review or mortality alert reviews.

5.3 Medical Examiners

The Medical Examiners will be responsible for:

- Providing a system to ensure that all patient deaths are reviewed at a level appropriate to the case
- Support and advice to family members to identify any concerns and provide Duty of Candour where any clinical issues are suspected.
- Liaison with HM Coroner where a reportable death has occurred or where the cause of death cannot be definitively identified.
- Education and support of clinical staff in respect of appropriate decision making and death certification

- Reporting of overall findings to HM Coroner
- Feedback to Learning from Deaths Manager where care or service delivery issues have been identified to allow a further Mortality Review using the Structured Judgement Process or clinical notes review by the specialty team.

5.4 Mortality Review Group

The Mortality Review Group will be responsible for:

- Providing assurance to the Governance Assurance Committee and Trust Board on patient mortality based on review of care received by those who die
- Agreeing and approving the mortality review proforma
- Reviewing M&M outcomes, audit data and action plans
- Identifying areas of high risk and agreeing and monitoring improvement plans
- Ensuring that feedback and learning points are shared with the divisions and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate.

5.5 Clinical Directors and Consultant Audit Leads

The Clinical Directors and Consultant Audit Leads will be responsible for:

- Participating in the Mortality Review Group and Clinical Outcomes Committee.
- Ensuring all deaths are reviewed using the Trust Structured Judgement Tool.
- Identifying clinicians to complete the mortality reviews and recording findings on the mortality review proformas
- Ensuring that all pertinent cases and findings from mortality reviews are presented by the appropriate clinical leads at specialty M&M meetings
- Ensuring that outcomes and learning from M&M meetings are recorded within the local Speciality Governance meeting minutes 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 of action plans and keeping
- governance informed
- Feeding back findings from mortality reviews and M&M meetings to the Learning from Deaths Manager and Mortality Review Group

5.6 Senior Nursing Staff

Senior Nursing staff will be responsible for:

- Participating in mortality reviews wherever possible, either in person or by nominated staff being available for advice on nursing issue

5.7 Clinical Coding Staff

Clinical Coding staff will be responsible for:

- Participating in mortality reviews where coding issues have been identified
- Routinely reviewing alerting diagnosis groups identified through Dr Foster

5.8 Learning from Deaths Manager and Clinical Governance Team

The Learning from Deaths Manager will be responsible for:

- Ensuring robust systems are used to identify and share learning from any death within the hospital.
- Maintaining the electronic database, linking the Medical Examiner Assessments and referrals to clinical reviews.
- Overseeing the process of mortality alert reviews and referrals from the Medical Examiner, HM Coroner or as a result of any incident or complaint.
- Production of speciality reports and the Quarterly Learning from Deaths report
- Coordinating feedback through the Mortality Review Group and Clinical Outcomes Committee.
- Coordination of all available data and analysis of Mortality reviews to identify themes, trends and associated learning
- Providing advice where a patient has died, to inform the Incident Investigation and learning Group
- Monitoring identified learning outcomes and associated action plans
- Ensuring learning outcomes and action points are included in the specialty audit programmes and Quality Improvement programmes as appropriate
- Supporting the review process with any identified duty of candour requirements
- Providing representation for the Trust within the Somerset Learning from Deaths Network Forum

6. CLINICAL CODING

6.1 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.

6.2 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.

6.3 This is supported as part of the mortality 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.

7. PROCESS FOR CARRYING OUT MORTALITY REVIEWS

7.1 The process for conducting a mortality review is outlined in the flow chart at Appendix 1. Key steps are described below:

7.2 Notification of patient deaths

- Patient deaths are notified through the Bereavement Office and the Medical Examiner Team
- Checks are made against any investigations commissioned and these are noted
- Where concerns have been raised about a patient's care and treatment, i.e. through an incident report or complaint, the case may require a full Mortality Review if this will provide more detailed information alongside the incident or complaint investigation.
- If there is an identified duty of candour requirement the clinicians or mortality reviewers should act according to the guidance in the relevant Trust policy.

7.3 Mortality reviews

All reviews should be recorded on the Trust's electronic Structured Judgement Tool assessment form. A three-stage process is used with those patients requiring a formal review identified through the formal Medical Examiner interventions at the time of completing the death certification. The three levels of review are described here

- Mortality review 1 - An initial assessment completed by the Medical Examiner to enable early identification of any case where a potential problem exists. Eg, where the cause of death does not follow from the admission diagnosis or a potential omission in care or poor management is identified. Cases are referred to the Specialty Team or the Mortality Review group through the Learning from Deaths Manager for a more detailed review.

- Mortality Review 2 - Cases identified for this type of review will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Deaths Manager within the Structured Judgement Review tool.

  The SJR tool summarises each review with an avoidability score. This is used to determine whether the information identified during the review, shows any evidence that the patient's death could have been avoided if different actions had been taken or the circumstances had been different. Some groups of patient will automatically be subject to a Mortality Review 2, where the number of deaths in the specialty is small, where the patient had a Learning Disability and where there is evidence of a hospital acquired COVID-19 infection which has been cited as the cause or contributed to the death.

- Mortality Review 3 - The third stage of the process involves the referral of any patient whose Mortality review has identified a degree of avoidability greater than 50% to the Mortality Review Group for verification and action. Cases may also include those where an incident investigation has been undertaken which does not cover the patient's death or where a case has been referred for a formal coroner's inquest.

Other investigation processes should continue where an incident has been reported, the Coroner is involved, or where other potential issues have been identified through the complaints or bereavement process. The Medical Examiners, Medical Examiner's Officer and Learning from Deaths Manager liaise closely to avoid duplication and ensure that all deaths in hospital are reviewed at an appropriate level. The Trust's Learning from Deaths Manager has responsibility for collating learning from all inpatient deaths whichever review method is used.

7.4 Outcomes

Outcomes are reported through the Incident Investigation and Learning Group, Local Governance Meetings, the Mortality Review Group and the Clinical Outcomes Committee as well as being summarised within the Quarterly Learning from Deaths report.

Discussions, outcomes and learning from all types of review will be recorded and fed back through the M&M meetings, including conclusions about outstanding care and sub-optimal care. Mortality reviews and in-depth reviews from M&M meetings should be used to inform any subsequent investigations, for example, SEA, SIRI, complaint or legal claim.

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 Duty of Candour Policy or via the Governance Team.

8. PROCESS FOR RESPONDING TO A MORTALITY ALERT (CUSUM)

If there are concerns about mortality in any particular patient group, (e.g. a CUSUM Alert from Dr Foster alert, elevated SMR for a particular diagnostic group, or global high weekend mortality) it will be necessary to undertake an in-depth case note review.

8.2 Alert received

The Monthly Dr Foster report presented at the Clinical Outcome Committee flags a CUSUM alert for the Trust.

8.3 Clinical coding review

- The correct cohort of patients should be identified and checked by the Clinical Coding Lead 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.
- If case numbers are below 10 a full review should be considered.

8.4 Approval of full case note review

- The need for a full case note review should be approved by the Clinical Outcomes Committee or Mortality Review Group at their next meeting. The Committee should also identify appropriate consultant(s) to undertake the review and the cohort of patients whose care and treatment require review.

8.5 Case note reviews

- The Governance Team will identify the relevant patient 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.
- The Clinical Outcomes Committee will coordinate the findings and ensure that CUSUM alerts are subject to a case note review where this is required
- 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 should be undertaken in order to establish whether the clinical care the patients received was appropriate.

8.6 Reporting findings

- A report should be constructed demonstrating methodology, findings, learning and recommendations and findings fed back through the Mortality Review Group to the Clinical Outcomes Committee.
- Reports from Performance (superspells and demographics of the whole cohort) and Clinical Audit (findings relating to the reviewed cases) should be produced to help populate the report with the relevant data.
- The identified lead for the review should add appropriate narrative and finalise the report, liaising with the Chief Medical Officer, Clinical Effectiveness Lead and Learning from Deaths Manager for action planning.

8.7 Clinical coding

Where clinical coding issues have been identified through a mortality review or as a result of a CUSUM alert review, the notes should be reviewed by the clinician, reviewer and Clinical Coding Lead to address the query. Findings from these review should be fed back to the clinicians to promote learning and improvement in documentation and coding.

9. FEEDBACK TO THE FRONTLINE

It is recognised that clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is therefore essential that there is a 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.

9.1 Mortality & Morbidity Meetings (M&M)

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.

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. For further information on the organisation and conduct of M&M meetings please see the associated M&M meetings standard operating procedure.

9.2 Governance Meetings

Outcomes and themes from all Mortality Reviews will be fed back through departmental Governance Meetings with Trust Wide Governance providing a forum for discussion of any wider issues.

9.3 Incident Investigation & Learning Group

Learning from all types of review following a patient's death will be discussed at the Incident Investigation & Learning Group to allow identification of themes and trends from all sources. This collaborative approach ensures that learning can be disseminated and actions identified across the disciplines. Actions can then inform future Quality Improvement projects.

9.4 Learning from Deaths Somerset Network

Participation in the Somerset Network allows sharing of information and learning across the county. This feeds into educational programmes and prompts collaborative working practices.

10. ASSOCIATED DOCUMENTATION

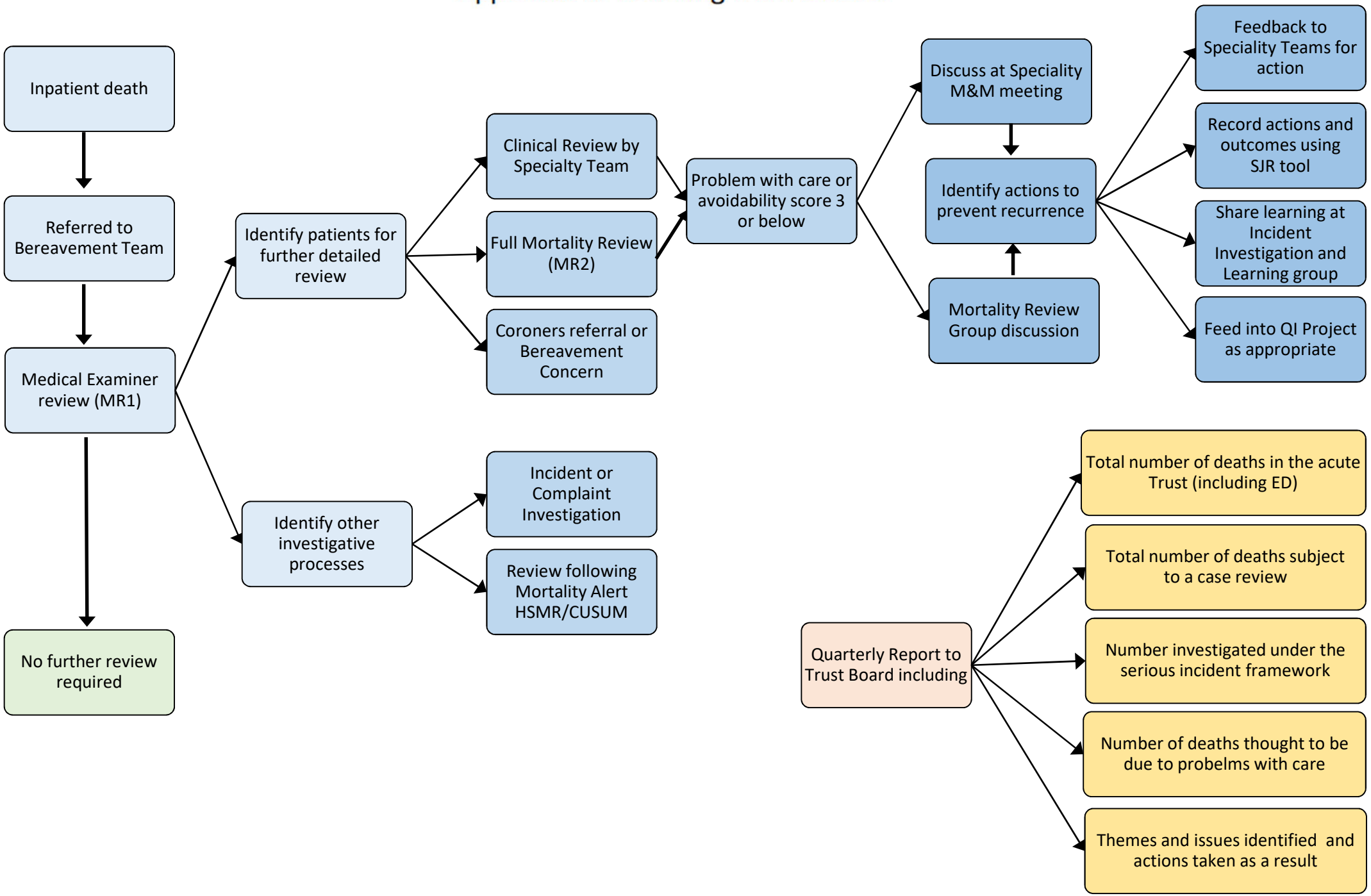
Yeovil District Hospital Trust Policies for:

- Incident Reporting and Investigation Management
- Complaints and Concerns
- End of Life
- Being open and the Duty of Candour

11. REFERENCES

- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of
- Surgeons (2015)
- 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
- Higginson J, Walters R, Fulop N, BMJ Qual Saf (2012), Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?
- Learning Disabilities Mortality Review (LeDeR) Programme (2017)
- National Guidance on Learning from Deaths, A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, 2017)

Appendix 1. Learning from Deaths



Appendix 2 – Equality Impact Assessment Tool

Name of Document: **Learning from Deaths - Mortality Review Process**

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	□ Race	No	
	□ Ethnic origins (including gypsies and travellers)	No	
	□ Nationality	No	
	□ Gender	No	
	□ Culture	No	
	□ Religion or belief	No	
	□ Sexual orientation including lesbian, gay and bisexual people	No	
	□ Age	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	-	
6.	What alternatives are there to achieving the policy/guidance without the impact?	-	
7.	Can we reduce the impact by taking different action?	-	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Name: Jo Howarth **Date:** 28/07/2017