Trust-wide Document

Great Western Hospitals NHS Foundation Trust

Learning from Deaths; Mortality Policy & Operational Processes

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Ratified by	Patient Quality Committee	**Date Ratified**	06.02.18
Date implemented (made live for use)	06.02.18	**Next Review Date**	06.02.21
Status	LIVE		
Target Audience- who does the document apply to and who should be using it.	All employees directly employed by the Trust (including those who deliver services on behalf of Wiltshire Health and Care), whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
Accountable Director		Medical Director	
Author/originator – Any Comments on this document should be addressed to the author		Trust Mortality Lead	
Division and Department		Corporate	
Implementation Lead		Trust Mortality Lead	
If developed in partnership with another agency ratification details of the relevant agency		Not Applicable	

Equality Impact
Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

Special Cases

The following are not included for implementation within this document:

- Child Deaths
- Perinatal Deaths
- Maternal Deaths

Contents

1 Document Details

1.1 Introduction and Purpose of the Document

In December 2016, the Care Quality Commission (CQC) published its report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* (Ref 1). It found that most trusts undertake some form of mortality review however, there was some considerable variation in terms of methodology, and contribution to learning from deaths was not given sufficient priority therefore valuable opportunities for improvements were missed. The report also pointed out that there was more that could be done in relation to the care of vulnerable people and engaging more with families and carers to recognise and learn from their insights.

In response to this, the *'Learning from Deaths'* (Ref 2) framework was published by the National Quality Board in April 2017, which outlines a framework for trusts to adopt in order to standardise reviewing and investigating deaths across the NHS. It is expected that acute trusts and other health care organisations should incorporate the guidance, aligning mortality and morbidity reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

This policy has been developed in response to the 'Learning from Deaths' (Ref 2) framework which states trusts are required to have an approved policy in place, outlining the operational processes for specific patient groups that must be subject to a mortality review and includes the following -

1. Elective Surgery
2. Learning Disabilities
3. Alerts via external monitoring bodies – i.e. CQC, Dr Foster
4. Family Concerns
5. Serious Incidents
6. Local Safety Initiatives – i.e. Cardiac Arrests
7. Other patient groups identified locally by Specialities

1.2 Purpose

This document sets out:

- How Great Western Hospitals NHS Foundation Trust (the 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.

- The procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.

- 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 its employees that may be affected by the death of someone in the Trust's care.

- 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 in conjunction with the following Trust policies:

1. Duty of Candour Policy (Ref 6)
2. Incident Management Policy (Ref 7)

3. Complaints Policy (Ref 8)

1.3 Glossary/Definitions

The following terms and acronyms are used within the document:

AHSN	Academic Health Science Network (South West)
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
DNAR	Do Not Attempt Resuscitation
ENT	Ears Nose and Throat
Frontline	Clinical Teams
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit
IV	Intravenous
LeDeR	Learning Disabilities Review programme
M&M	Mortality and Morbidity
MINAP	Myocardial Ischaemia National Audit Project
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcomes and Deaths
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PQC	Patient Quality Committee
PRISM	Preventable Incidents, Survival and Mortality
SJR	Structured Judgement Review
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
TEP	Treatment Escalation Plan
VTE	Venous thrombo embolism

The National Guidance on Learning from Deaths (Ref 2) includes a number of terms. These are defined below:

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.

Case record review
A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or employees raises concerns about care.

Mortality review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

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. See the Serious Incident framework for further information. See the Incident Management Policy (ref 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.

Death due to a problem in care
A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

3 Main Policy Content Details

3.1 Requirements for Compliance with National Guidance on Learning from Deaths Findings

Under the National Guidance on Learning from Deaths, published by the National Quality Board in March 2017, trusts are required to:

- Publish an updated policy and made available on the their website, on how their organisation responds to and learns from deaths of patients, who die under their management and care, including:
  - How their 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
  - Their evidence-based approach to undertaking case record reviews
  - The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
  - How the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
  - How staff affected by the deaths of patients will be supported by the trust.

- Collect specific information every quarter on:
  - The total number of inpatient deaths in an organisation's care
  - the number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies e.g. inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
  - The number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
  - Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
  - 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 Trust's approach to meeting these requirements.

3.1 Operational process

The Operational Process has been designed to ensure that all aspects of the Learning from Deaths guidance are fully implemented and is outlined in Appendix C.

- Doctor or qualified Nurse completes diagnosis of death on the ward.
- Nurse present completes notification of death and mortuary checklist.
- Ward Clerk updates deceased status on Medway.
- Daily mortality lists sent to all wards from informatics department (automated).
- Ward Clerk 'validates' Consultant and Speciality.
- Deceased patient level data uploaded to the local Mortality database weekly.
- Central support teams identify mandatory cases for Structured Judgement Review (SJR)
- Speciality Mortality & Morbidity (M&M) identify and undertake SJR recording review details onto database.
- Clinical Audit populate speciality M&M dashboards from database.
- Dashboards shared with speciality M&M lead and Trust Mortality Group.

- Clinical Audit extract mandatory statistics for reporting
- Mandatory report shared and reviewed at Trust Mortality Group
- Trust Mortality Group report into Patient Quality Committee (PQC) meeting, Trust Board and local Clinical Commissioning Group

3.2 Identifying Deaths for Case Record Review

Specific patient groups that MUST be subject to mortality review and includes the following -

1. Elective Surgery
2. Learning Disabilities
3. Alerts via external monitoring bodies – i.e. CQC, Dr Foster
4. Family Concerns
5. Serious Incidents
6. Local Safety Initiatives – i.e. Cardiac Arrests
7. Other patient groups identified locally by Specialities

Please see Appendix C for inclusion and review process.

Note: this process does not include reviews for stillbirths/maternal/infants deaths. Please contact the Head of Midwifery/Maternity Lead for local information about Perinatal M&M and the Paediatrics/ Children's and Young People Lead for local information about Child Death review processes.

3.3 Purpose and Objectives of Departmental/Specialty Mortality & Morbidity Meetings

The purpose of the Mortality and Morbidity Meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of treatment for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

The Trust will take a collaborative approach when it comes to mortality reviews, for example, by participation with the Allied Academic Health Science Network (AHSN) Collaborative (South West).

3.4 Review Methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or employee raises concerns about care.

Patient Group	Methodology for Case note review in the Trust
Adult inpatient	Structured Judgement Review (Appendix G)
Mental health	Structured Judgement Review (Appendix G)
Child (under 18)	Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* (2015) (Ref 4) and the current child death overview panel processes.
Learning disability	All trusts should adopt the Learning Disabilities Review programme (LeDeR) (Ref 5) method to review the care of individuals with learning disabilities.
Perinatal and maternity	All perinatal deaths should be reviewed, using the new perinatal mortality review tool (Ref 6). Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly using the Trust's incident reporting processes (Ref 7)

Data from mortality reviews should be collected using an electronic tool which is based on identifying preventable incidents. Please refer to NHS England guidance. Appendix D

3.5 Selecting Deaths for Additional Investigation

Where a review carried out by the Trust under the process above, identifies patient safety incident(s) that require further investigation, this will be reported as a clinical incident and assessed against the Trust's Serious Incident framework. (Ref 7)

Within the SJR process, any case where either a phase of care or the overall care of the patient is assessed as poor (score 2) or very poor (score 1) will be reported via the Trust's Incident Reporting System and will be subject to a higher level review and or investigation.

3.6 Reviewing Outputs from Review and Investigation to Inform Quality Improvement

Discussions and outcomes from M&M's should be recorded including the conclusions around sub-optimal and/or outstanding care. Associated minutes should be produced for circulation and reporting to the Divisional Board and Mortality Group. Please refer to Trust Mortality Group and individual Department Terms of Reference for reporting arrangements. Appendix E & F.

3.7 Feedback to the Frontline

Clinical teams must be kept informed of the outcomes of their work if they are to learn and improve. There must be mechanisms in place for M&M discussions and learning to be fed back to employee as well as plans for improvement, lessons learnt and pathway re-design.

Examples of capturing and sharing information can include –

- Department/Divisional Dashboards.
- Safety Lesson of the Week.
- Email Alerts.

4 Protected Characteristics Provisions

None.

5 Duties and Responsibilities of Individuals and Groups

5.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

5.2 Trust Board

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 in order that the executives remain aware and non-executives can provide appropriate challenge. 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 (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved and,
- Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

5.3 Non-executive Directors

The Board of Directors are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the Council of Governors.

Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

Providers should ensure such activities are adequately resourced.

Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

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.

Executive and Non-executive Directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

- The processes their organisation has in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support

- Quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change

- The information the provider publishes is a fair and accurate reflection of its achievements and challenges.

The Trust is required to collect and publish data to monitor trends in deaths. Alongside this, they will need to establish an on-going learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, Non-executive Directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of Non-executive Directors include:

- Understand 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?
    - Are they sufficiently senior/experienced/trained?

- Seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons.
- Ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation.
- Is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
- How was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
- Are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
- For coordination of responses to reviews/investigations through the provider's clinical governance processes, 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 provider's 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 that relevant team are working towards a 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.

5.4 Medical Director

Executive lead for mortality reviews; to support the Trust Mortality Lead on –

- Producing a Mortality Reduction Strategy that aligns the Trust's systems such as audit, information services, training and clinical divisions.

- Reviewing on a monthly basis, the benchmarked mortality rates/trends.
- Ensuring mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- Reporting on Mortality performance to the Board.

5.5 Learning Disability/Mental Health Lead

The Learning Disability/Mental Health Lead is responsible for the identification of Learning Disability deaths; undertaking local SJR and ensuring compliance with the National LeDeR programme. (Ref 4).

5.6 Head of Midwifery/Maternity Lead

The Head of Midwifery/Maternity lead is responsible for ensuring compliance with Perinatal Mortality processes/review programme, as required by Local and National requirements. (Ref 5).

5.7 Paediatrics/Children's and Young People Lead

The Paediatrics/Children's and Young People Lead is responsible for ensuring compliance with Child Death Review processes/review programme, as required by Local and National requirements. (Ref 3).

5.8 Trust Mortality Lead

The Trusts Mortality Lead is responsible for:

- Supporting the alignment of department Mortality and Morbidity meetings for the purpose of reducing all avoidable deaths.
- Providing senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings.
- Supporting the implementation of mortality reduction strategy that aligns hospital systems such as audit, information services and training.
- Reviewing on a monthly basis, the benchmarked mortality rates/trends for the speciality/service/high risk groups.
- Investigating any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems (e.g. Dr Foster).
- Considering the mortality data in conjunction with analysis of the case note review and identify areas for future investigation.
- Supporting and agree action plans and methodologies that are designed to reduce Mortality and Morbidity across the department/speciality.
- Signing off regulatory mortality responses.
- Reporting on mortality performance to the PQC.
- Reviewing the effectiveness of the Mortality and Morbidity Meeting annually.

5.9 Speciality M&M Lead

The Trusts Speciality M&M lead is responsible for

- Supporting the alignment of department Mortality and Morbidity meetings for the purpose of reducing all avoidable deaths
- Providing senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- Supporting the implementation of mortality reduction strategy that aligns hospital systems such as audit, information services and training

- Signing off action plans and methodologies that are designed to reduce Mortality and Morbidity across the department/speciality
- Signing off regulatory mortality responses
- Reporting on Mortality performance to the Mortality Group
- Reviewing the effectiveness of the Mortality and Morbidity Meeting annually.

5.10 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

5.11 Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

5.12 The Trust Mortality Group

The Trust Mortality Group is responsible for working towards the elimination of all avoidable in-hospital mortality by :

- Reviewing on a monthly basis, the benchmarked mortality rates/trends for the speciality/service/high risk groups (Appendix A)
- Developing M&M minutes/reports/dashboard; to mirror department reporting in order to provide assurance to the Trust Board on patient mortality.
- Reviewing themes or significant learning arising from departmental Mortality and Morbidity meetings reported by department/team M&M lead/s and to ensure mechanisms are in place to feed back, learn and improve practice from this learning.
- Considering the mortality data in conjunction with analysis of the case note review and identify areas for future investigation.
- Facilitating the use of Clinical Databases, run by various bodies including professional societies for the assessment of in-hospital mortality.
- Investigating any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems (e.g. Dr Foster, HED, etc.).
- Developing data collection systems to ensure the Trusts mortality data is timely robust and in line with national and international best practice.
- Ensuring mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- Developing an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
- Assigning clinical leads to address increased mortality in particular clinical areas by the deployment of evidence based interventions such as care bundles. The chair will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
- Reviewing and monitor compliance with other Hospital policies including DNAR and Death Certification Policy through the process of case note review.

- Working with established groups to ensure each junior doctor intake receives the latest guidelines on M&M processes, care protocol implementation and clinical coding best practice.
- Acting as the strategic hospital mortality overview group with senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings.
- Producing a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical divisions. This strategy will be reviewed on an annual basis by the Medical Director.
- Agreeing with Divisions and departments action plans that are designed to reduce Mortality and Morbidity across those departments/specialities.
- Preparing of regulatory mortality responses for sign off by Executive Director(s)
- Reporting on Mortality performance to the Board.
- Reviewing the effectiveness of the Mortality Group annually.

6 Monitoring Compliance and Effectiveness of Implementation

The Trust Mortality Group will monitor the implementation of the policy on a monthly basis.
The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified?**
100 percent compliance with the collection and Publication of specific information on a quarterly basis to ensure learning and sharing	Monitored via Mortality Database	Trust Mortality Group	Monthly	Trust Mortality Group	Escalation to PQC
100 percent specialities to undertake M&M meetings (where relevant)	Monitored via Mortality Database	Trust Mortality Group	Monthly	Trust Mortality Group	Escalation to PQC
100 percent specialities to have dashboards in place in order to capture and report discussions and learning (where relevant)	Monitored via Mortality Database	Trust Mortality Group	Monthly	Trust Mortality Group	Escalation and non-compliance to PQC

7 Review Date, Arrangements and Other Document Details

7.1 Review Date

This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

7.2 Regulatory Position

CQC (Care Quality Commission) regulate the Trusts activity and its right to provide services.

7.3 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	National Guidance on Learning from Deaths	https://www.england.nhs.uk
2	Learning, Candour and Accountability; A review of the way NHS trusts review and investigate the deaths of patients in England	http://www.cqc.org.uk
3	National Guidance on Learning from Deaths	https://www.england.nhs.uk
4	Working together to Safeguard Children 2015	https://www.gov.uk
5	Learning Disabilities Review Programme (LeDeR)	http://www.bristol.ac.uk
6	Perinatal Mortality Review Tool	https://www.npeu.ox.ac.uk
7	Duty of Candour Policy	T:\Trust-wide Documents
8	Incident Management Policy	T:\Trust-wide Documents
9	Complaints Policy	T:\Trust-wide Documents

7.4 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultees Agreed Document Contents
Wiltshire Health and Care – Inpatient Services Manager	06/10/2017
Speciality M&M Lead – General Surgery	06/10/2017
Paediatric Safeguarding Lead	06/10/2017
Quality Lead (Corporate Services)	19/09/2017
Medical Director	06/10/2017
Trust Mortality Lead	09/10/2017

Appendix A – Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

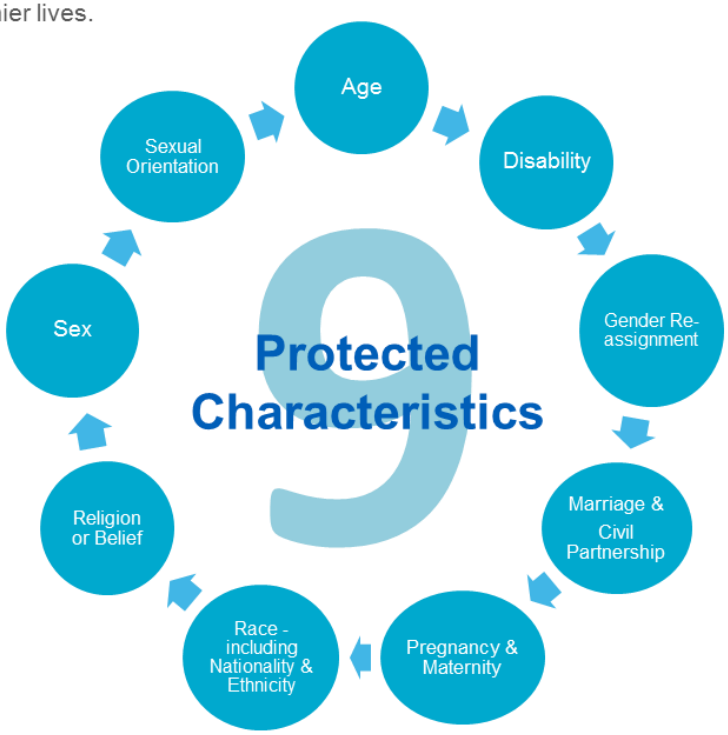
Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



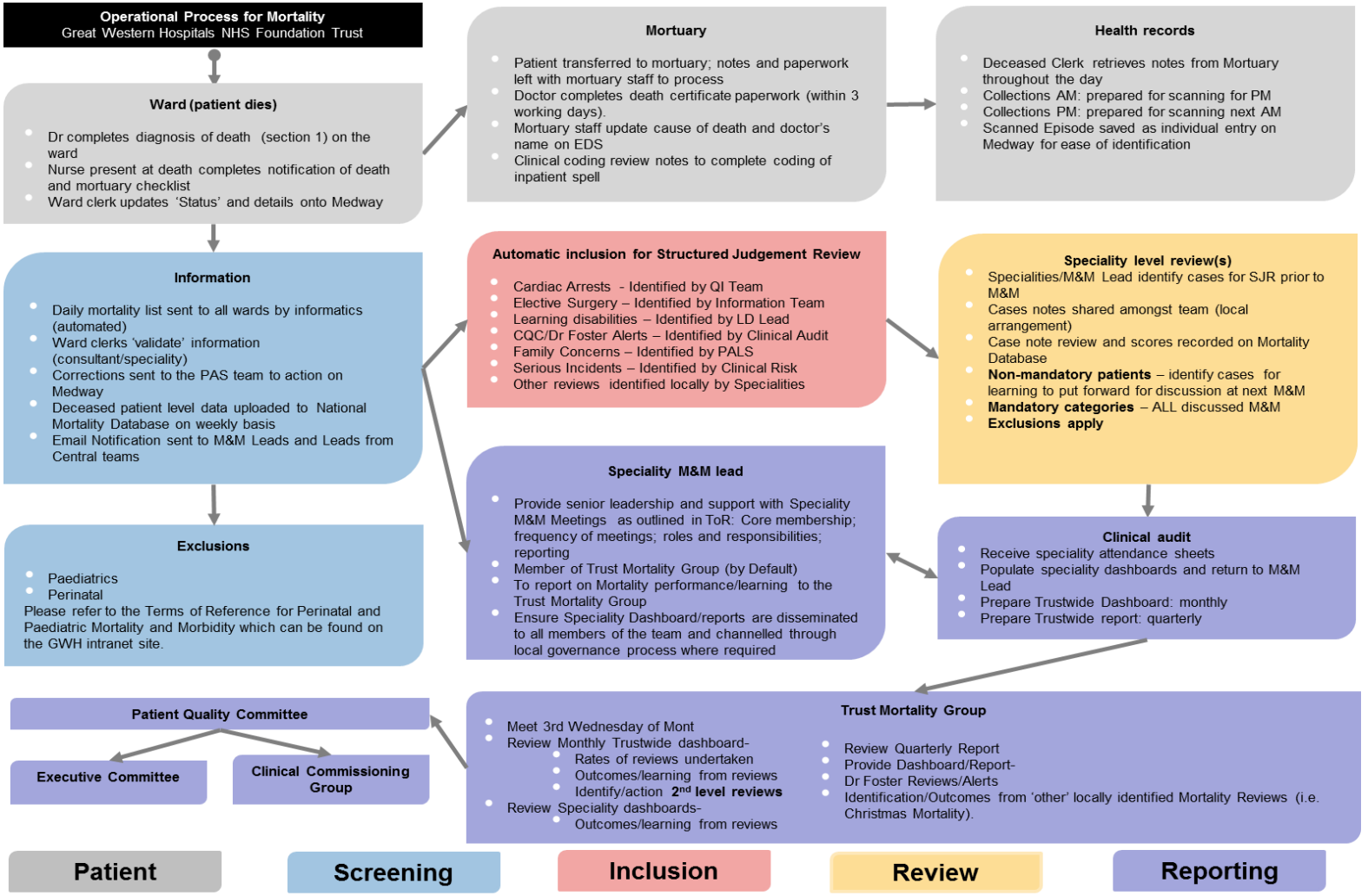
Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Appendix B – Quality Impact Assessment Tool

Purpose - To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community.			
Process -The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.			
Monitoring the Level of Risk - The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. High Risks must be reported to the relevant Executive Lead.			
Impact Assessment Please explain or describe as applicable.			
1.	Consider the impact that your document will have on our ability to deliver high quality care.	The purpose of this document is to provide guidance for healthcare professionals in the process of Mortality Reviews. This in turn will provide opportunities for learning and encourage the drive for improvements and encourage the delivery of high quality care.	
2.	The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care).	Positive Impact. Quality Improvement is expected by the nature of the Structured Judgement Review Process.	
3.	Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall.	No service impact is expected.	
4.	Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is.		Not Applicable
Impact on Clinical Effectiveness & Patient Safety			
5.	Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm.	Positive impact. Implementing this Policy will support health care professionals to continuously review clinical practice and identify areas for improvements. Improving patient outcomes, safety and services delivered.	
Impact on Patient & Carer Experience			
6.	Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment.		As above
Impact on Inequalities			
7.	Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language).		None.

Appendix C – Operational Process for Mortality



Appendix D – Guidance on Data Collection and Review

NHS England has provided the following guidance on data collection and review:

Data from mortality reviews should be collected using a bespoke proforma created by the clinical team; ideally this should be electronic. The proforma should be based on identifying preventable incidents and initial assessment should include:

- Demographic details
- Mode of admission
- Initial clinical assessment
- On-going management
- Investigations
- Interventions
- Issues around – Infection, Venous Thrombo Embolism , Hydration and Nutrition
- Recognising deterioration
- Use of critical care services
- End of Life care and the appropriateness of DNAR assessment

Additionally, measurements and standards relating to NICE guidelines and the Royal Colleges should be included in order to focus the review to a specific area, for example;

- Acute medicine
- Stroke
- Fracture Neck of Femur
- End of Life

M&M review meetings should include a review of statistical information concentrating on relevant factors such as:

- Trends highlighted by hospital mortality indicators, for example:
- by speciality
- diagnostic group
- referral source; mortalities within 24-36hours of admission

Patient safety indicators for example: falls, unexpected return to theatres, post op infections

- Include specialist/high risk groups such as:
- Sepsis,
- Pneumonia,
- Stroke,
- Myocardial Infarction,
- Heart Failure,
- Acute Kidney Injury
- Fractured Neck of Femur

Link in relevant mortality data associated with National Audits to identify where needs to be improved, for example care:

- Intensive Care National Audit & Research Centre (ICNARC)
- Trauma Audit and Research Network (TARN)
- National Bowel Cancer
- Myocardial Ischaemia National Audit Project (MINAP)
- Sentinel Stroke National Audit Programme (SSNAP)

Departments/clinical teams should give M&M meetings and governance arrangements equal priority to other Multi-disciplinary Team meetings.

Appendix E – Department Mortality & Morbidity Review Meetings

Department Mortality and Morbidity Review Meetings

Established by Mortality Group

Reports and accountable to the Mortality Group

(Non-Statutory)

Overview

Concerns about patient safety and an increased level of scrutiny of hospital mortality rates have led to a drive for NHS Trusts to review and implement appropriate changes to ensure the delivery of safe, quality care.

In response to this, NHS England published the 'Mortality Governance Guide' in December 2015, which outlines general principles around mortality reviews; it is expected that acute trusts and other health care organisations should incorporate this guidance, aligning Mortality and Morbidity Reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

Purpose and objectives of Departmental/Specialty Mortality & Morbidity Meetings

The purpose of the Mortality Group meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of care for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

Note: this process does not include reviews for stillbirths/maternal/infants deaths. Please refer to the Terms of Reference for Perinatal Mortality and Morbidity which can be found on the Trust's intranet site.

Membership:

Core representation at Department M&M meetings should include:

- All consultants within the speciality
- Junior Doctors
- Senior nursing staff (Speciality specialist nurses, speciality ward and matrons where appropriate)
- Junior Nursing staff
- Key Allied Health Care Professionals – where relevant to department/speciality

Other invitees can include:

- Doctors– where relevant from other specialist groups (e.g. anaesthetics for surgical patients or ITU)
- Clinical Audit
- Clinical Coding
- Representation from the Information Team

Quorum
To be agreed by individual speciality M&M as this will vary depending on the size of each department and grades within each team.
For example, it could be agreed that for X department this will consist of the Speciality M&M Lead and XYZ members (of which, will include at least an agreed minimum number of consultants).

Frequency of Meetings
In general, to discuss deaths soon after they occur, meetings will be held monthly. For specialities with high numbers of deaths, more frequent meetings may be required to ensure a mechanism for good quality discussion and regular learning is in place.

For departments with low death rates, meetings may be held less frequently but they should still be held as they represent an opportunity to discuss morbidity and to learn and improve patient pathways. Meetings that are required less frequently could be incorporated in departmental governance meetings.

For the xxxxxxxx department, the meeting frequency will be xxxxxxxx (e.g. fortnightly, monthly, or quarterly)

Operational Functions:
To work towards the elimination of all avoidable in-hospital mortality.
The responsibility of department/clinical teams' mortality and morbidity reviews should be distributed amongst ALL consultants/senior members in order for them to understand the outcomes of their clinical practice. Each department/speciality should identify a Mortality and Morbidity Lead who will be the department/specialty representative and will be required to attend the monthly Mortality Group meetings.

- To share learning from department Mortality and Morbidity meetings across the wider system.
- To consider mortality data specific to the department in conjunction with case note review and identify areas for investigation and areas for improvement. For the xxxxx department this will include data from yyyyy and zzzz.
- To lead on in depth review where concerns are highlighted; with an identified lead for the review and writing up results
- To learn from reviews; develop ideas and formulate proposals for implementation.
- To develop M&M minutes/reports/dashboard; provide assurance to the Mortality Group / Division / Trust Board on patient mortality
- To ensure that the departmental M+M meeting is aligned with the operational functions of the Mortality Group as listed in the Terms of Reference for that group.

Roles and Duties of Department/ Team M&M Lead
- To support the alignment of department Mortality and Morbidity meetings for the purpose of reducing all avoidable deaths
- To provide senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- To support the implementation of mortality reduction strategy that aligns hospital systems such as audit, information services and training
- Sign off action plans and methodologies that are designed to reduce Mortality and Morbidity across the department/speciality
- Sign off regulatory mortality responses
- To report on Mortality performance to the Mortality Group
- To review the effectiveness of the Mortality and Morbidity Meeting annually.

Accountability/Reporting
Discussions and outcomes from the meeting should be recorded including the conclusions around sub-optimal and/or outstanding care. Associated minutes should be produced for circulation to the Divisional Board and Mortality Group.

There should be a standard scale to classify the care delivered for each mortality case reviewed and discussed. The NCEPOD (National Confidential Enquiries into Patient Outcomes and Death) Classification should be used as below:

- Good Practice – The standard you would expect from yourself, your trainees and your institution.
- Room for Improvement – Aspects of Clinical care could have been better.
- Room for Improvement – Aspects of Organisational care could have been better.
- Room for Improvement – Aspects of both Clinical & Organisational care that could have been better.

Less than Satisfactory – Several aspects of clinical and/or Organisational care that were well below what you would accept from yourself, your trainees and your institution.

Feedback to the Frontline
Clinical teams should be kept informed of the outcomes of their work if they are to learn and improve. There should be mechanisms in place for learning to be fed back to staff as well as plans for improvement, lessons learnt and pathway re-design.

Examples of capturing and sharing information can include –

- Department/Divisional Dashboards
- Safety Lesson of the Week
- Email Alerts

Review
These Terms of Reference were agreed by the Patient Quality Committee in June 2016.
Annual Review due: June 2018

Appendix F – Trust Mortality Group Meetings

Trust Mortality Group Meetings

Reports and accountable to the Trust board

(Non-Statutory)

Overview

Concerns about patient safety and an increased level of scrutiny of hospital mortality rates have led to a drive for NHS Trusts to review and implement appropriate changes to ensure the delivery of safe, quality care.

In response to this, NHS England published the 'Mortality Governance Guide' in December 2015, which outlines general principles around mortality reviews; it is expected that acute trusts and other health care organisations should incorporate this guidance, aligning Mortality and Morbidity Reviews with their governance systems, in order to measure assurance of the provision of safe, effective care focusing on the systems and processes used in the service.

Purpose and objectives of Mortality Group Meetings

The purpose of the Mortality Group meetings is to establish a consistent and robust process to identify and reduce all avoidable in-hospital mortality by:

- Systematically reviewing care through a structured analysis of patient records
- Focusing on reducing complications
- Improving patient pathways (reducing variability of care)
- Improving early recognition and escalation of care for deteriorating patients
- Learning from problems that contribute to avoidable patient death and harm
- Sharing the learning; promoting best practice and behaviours across the organisation

Note: this process does not include reviews for stillbirths/maternal/infants deaths. Please refer to the Terms of Reference for Perinatal Mortality and Morbidity which can be found on the GWH intranet site.

Membership:

Core representation at the Trustwide Mortality Group meetings includes:

- Chair – Trust Mortality Lead
- Representation from leads of departments that conduct mortality and morbidity meetings:
    - Acute Medical Unit
    - Gastroenterology
    - Respiratory
    - Cardiology
    - Department of Medicine for the Elderly
    - Diabetes
    - Endoscopy
    - Obstetrics and Gynaecology
    - General Surgery
    - Urology*
    - ENT*
    - Haematology/Oncology
    - Emergency Department
    - Intensive Care Unit
    - Anaesthetics
- Junior Doctor Representative
- Nursing Representative

Other invitees/specialities include:

- Pathology
- Paediatrics* – where relevant

- Midwifery* – where relevant
- Palliative Care Medicine and nursing
- Clinical Audit
- Clinical Coding
- Representation from the Information Team

*denotes quarterly attendance or when deaths have occurred as they are rare in these departments.

Quorum
Six members plus the Trustwide Mortality Lead
Five clinical (medical or nursing staff and a governance representative)

Frequency of Meetings
Meetings will normally be held monthly

Reporting and Accountability
The Mortality Group is formally accountable to the Trust Board and reports to the Patient Quality Committee.

Operational Functions:

To work towards the elimination of all avoidable in-hospital mortality.

- To review on a monthly basis, the benchmarked mortality rates/trends for the speciality/service/high risk groups (Appendix A)
- To develop M&M minutes/reports/dashboard; to mirror department reporting in order to provide assurance to the Trust Board on patient mortality.
- To review themes or significant learning arising from departmental Mortality and Morbidity meetings reported by department/team M&M lead/s and to ensure mechanisms are in place to feed back, learn and improve practice from this learning.
- To consider the mortality data in conjunction with analysis of the case note review and identify areas for future investigation.
- To facilitate the use of Clinical Databases, run by various bodies including professional societies for the assessment of in-hospital mortality.
- To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems (e.g. Dr Foster, HED, etc.).
- To develop data collection systems to ensure the Trusts mortality data is timely robust and in line with national and international best practice.
- To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of learning and clinical excellence.
- To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
- To assign clinical leads to address increased mortality in particular clinical areas by the deployment of evidence based interventions such as care bundles. The chair will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
- To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy through the process of case note review.
- To work with established groups to ensure each junior doctor intake receives the latest guidelines on M&M processes, care protocol implementation and clinical coding best practice.

Strategic Function:

- To act as the strategic hospital mortality overview group with senior leadership, support and overview of the Departmental/Team Mortality and Morbidity meetings
- To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical divisions. This strategy will be reviewed on an annual basis by the Medical Director

- Agree with Divisions and departments action plans that are designed to reduce Mortality and Morbidity across those departments/specialities
- Preparation of regulatory mortality responses for sign off by executive director(s)
- To report on Mortality performance to the Board
- To review the effectiveness of the Mortality Group annually

Feedback to the Frontline
Clinical teams should be kept informed of the outcomes of their work if they are to learn and improve. There should be mechanisms in place for learning to be fed back to staff as well as plans for improvement, lessons learnt and pathway re-design.

Examples of capturing and sharing information can include –
- Department/Divisional Dashboards
- Safety Lesson of the Week
- Email Alerts

Review
These Terms of Reference were agreed by the Patient Quality Committee in June 2016.
Annual Review due: June 2018

Appendix G – Structured Judgement Review Data Collection Form

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Age at death (years): Sex:

M/F

First 3/4 digits of the patient's postcode: Day of

admission:

Time of admission:

Day of death: Time

of death:

Number of days between admission and death:

Month cluster during which the patient died:
Dec/Jan/Feb Mar/Apr/May Jun/Jul/Aug Sept/Oct/Nov

Specialty team at time of death: 1 – Surgical, 2 – Medical

Type of admission: 1 – Emergency, 2 – Elective, 3 – Day case Recorded

cause of death:

Risk factors

Did the patient have a learning disability?

1. No indication of a learning disability – proceed with this review.
2. Yes – clear or possible indications from the case records of a learning disability. Action: after your review, please refer the case to the hospital's clinical governance group to link with the Learning Disability Mortality Review Programme.

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgments about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgments about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgments about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgments about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Implicit structured case note review data collection sheet

Phase of care: **Overall assessment**

Please record your explicit judgments about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = Excellent care**

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick) No

☐ (please stop here) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐

☐ ☐ ☐

Did the problem lead to harm? No Probably Yes

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐ **Did the problem lead to harm? No** ☐ **Probably** ☐ **Yes** ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐

☐ ☐ ☐

Did the problem lead to harm? No Probably Yes

4. **Problem with infection control Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5. **Problem related to operation / invasive procedure** *(other than infection control)* **Yes** ☐ **Did the problem lead to harm? No** ☐ **Probably** ☐ **Yes** ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐

Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

8. **Problem of any other type not fitting the categories above Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

Avoidability of death judgement score (only at second-stage reviews)

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 Definitely not avoidable

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.