Learning from Deaths; Mortality Review Policy

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New or Replacement:	Replacement
Policy number:	CESC/2012/066 (Version 4)
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Executive Sponsor:	Dr Neill Hepburn, Medical Director
Non-Executive Sponsor:	Penny Owston, Vice Chair
Title of person responsible for review of document (e.g. Deputy Chief Nurse or Trust Lead)	Quality and Safety Manager, ULHT
Approved by:	Clinical Effectiveness Steering Committee
Date approved:	28 September 2017 (Chair of CESC)
Review date:	September 2020

Policy is:	Trust-wide

Version History Log

Version	Date Implemented	Details of key changes
3.0	August 2016	Document up-dated to reflect current practice.
4.0	September 2017	Document up-dated to reflect new guidance and current practice.

Contents

1. Introduction

1.1 Preservation of life and avoidance of unnecessary death is an essential objective for health care providers.

1.2 A structured mortality review process is a way to analyse mortality statistics, monitor sentinel health events, and provide a qualitative review of individual events.

1.3 The aim of a mortality review is to learn and share from a patient's death, to identify if similar situations may affect other patients and to improve overall quality of care.

1.4 The Care Quality Commission (CQC) use hospital level mortality rates as one the essential standards for monitoring the quality of care provided by individual hospitals.

2. Purpose

2.1 A structured judgement mortality review process results in system-wide quality enhancement.

2.2 Mortality reviews should be conducted to:

- Determine if there are any areas that need immediate resolution.
- Determine contributing factors of the circumstances surrounding the individual's death.
- Identify patterns or trends of concern.
- Determine whether changes are needed to prevent similar circumstances affecting other patients .
- Propose care and treatment recommendations if appropriate.
- For any reviews that are suboptimal will be reviewed for assurance by the Mortality Review Action Group (MoRAG).
- For any reviews that are inappropriate admissions, passed away within 48 hours of admission and within 30 days of discharge will be reviewed for assurance by the Lincolnshire Mortality Collaborative.
- Enable shared learning and improvement within the Trust and Community.
- Provide assurance to the board.

3. Scope

The policy will apply to all health professionals employed (either permanent or temporary) by United Lincolnshire Hospitals NHS Trust (ULHT).

4. Definitions

4.1 Standardised Mortality Ratio (HSMR) is the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rate as some reference population e.g. the hospitalised population of England.

SMR = (the number of observed deaths divided by the number of expected deaths) x 100.

4.2 Hospital Standardised Mortality Ratio (HSMR) is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of fifty six diagnoses which give rise to 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary User Service Data (SUS) or Commissioning Datasets (CDS).

4.3 A mortality review is the process of reviewing individual patient case notes to determine if the patient received appropriate care and if there are any lessons to learn which may improve the care provided for future patients.

4.4 Death rate is the number of people who die in relation to the size of the population in which the people live. This measure is usually known as a crude rate.

4.5 It is usual practice to set the baseline SMR in the standard population at a value of 100. This means there is an exact match between the observed deaths and the expected deaths.

4.6 Mortality Outlier Alert – The Dr Foster Audit Tool alerts the Trust when an alert occurs on cumulative sum charts.

4.7 The Trust also pre-empts the data to highlight areas as outliers so the Trust does not wait for these alerts from Dr Foster prior to a review occurring.

5. Roles and Responsibilities

5.1 The Medical Director and a named Non-executive Director are responsible for ensuring Mortality Review processes are in place.

5.2 The Patient Safety Committee are responsible for supporting the Medical Director and the Non-executive Director in ensuring that there are effective transparent mortality monitoring and review process within the Trust.

5.3 Consultants have the responsibility of:

- Monitoring their patients mortality and morbidity data
- Ensuring that effective mortality reviews are undertaken

- Take action when required for suboptimal care
- Sharing Lessons Learned
- Using the lessons learned to improve patient care

5.4 Clinical Directorates are responsible for governance processes to facilitate effective mortality review to be undertaken.

5.5 The Quality Governance Department unit are responsible for:
- Facilitating and monitoring mortality reviews
- Undertaking monthly analysis of mortality data
- Facilitating the review process when an alert occur
- Escalating reviews to the correct overarching committee; MoRAG or the Lincolnshire Mortality Collaborative
- Producing the Trust Mortality Report

5.6 The Quality Safety Officers are responsible for:
- the speciality governance meetings contain the following information; mortality reviews, mortality alerts and lessons learned.

6. Mortality Review Process

6.1 All specialities undertake mortality reviews. Where lessons can be learned these are shared at speciality-level and Clinical Directorate governance meetings.

6.2 The Trust will review 70% of all adult inpatient deaths. Quality Governance will facilitate the review process. The Bereavement Team, Risk Team and Complaints will highlight the “Must Do Reviews” for the Trust which encompasses the following;
- serious incident
- complaint
- concerns from the family
- all learning disability
- mental health mortalities.

6.3 Within the Women and Children’s Clinical Directorate; all mortalities within the Directorate are discussed and an IR1 raised on datix. These are reported Quarterly to the Patient Safety Committee.

6.4 Case notes should be reviewed by a Clinician that has sufficient clinical knowledge to make valued judgements; however case note reviews are **NOT** to be undertaken by the consultant who was primarily involved in the patients care immediately prior to death. Clinician’s will have 2-3 reviews per month with a 4 week deadline. The reviews will be sent by Quality Governance via an electronic proforma and review compliance is kept on the Hospital Sites register.

6.5 Mortality Review training is incorporated into the Clinical Coding Masterclasses held quarterly within the Trust.

6.6 Reviews are classified using the following grades:

Grading
Grade 0-Unavoidable death, no suboptimal care
Grade 1-Unavoidable death, suboptimal care but different management would NOT have affected outcome
Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

7. Speciality Level Mortality Review Process

7.1 The purpose of speciality level reviews is to monitor the quality of care. All specialities have processes in place to carry out mortality reviews on all deaths and facilitate learning. It is a standard agenda item within the monthly Specialty Governance Meeting.

8. Mortality Surveillance Groups

8.1 The Mortality Review Assurance Group (MoRAG) is a multi-disciplinary and multi-professional group that meets monthly and are responsible for carrying out the following functions (Appendix C Terms of reference):

- Reviewing the quality of mortality reviews graded 1 or above carried out at specialty level
- Completing an independent review from those cases referred from speciality level.
- Identifying areas of system or systematic failing and good practice
- Recognising and sharing lessons learned MoRAG Briefings.
- Providing feedback to clinicians carrying out mortality reviews.
- Undertaking further case review where concerns have been raised through specialty governance, complaints, never events or serious incidents
- If required completing an IR1 (Datix) for an Serious Incident to be investigated.

8.2 The Lincolnshire Mortality Collaborative is a multi-disciplinary and multi-agency group that meets 6 weekly and are responsible for carrying out the following functions (Appendix D Terms of reference):

- Reviewing patients that have been deemed as inappropriate admissions of the reviews carried out at specialty level.
- Reviewing patients that have passed away within 30 days of discharge and within 48 hours admission to the hospital.
- Identifying areas of concerns and good practice Countywide.
- Recognise and share lessons learned Countywide.
- Providing feedback and share learnings to Clinicians within ULHT, General Practitioners, Nursing/Residential homes

9. HSMR

9.1 The HSMR should not be looked at in isolation; it is an indicator to prompt investigation.

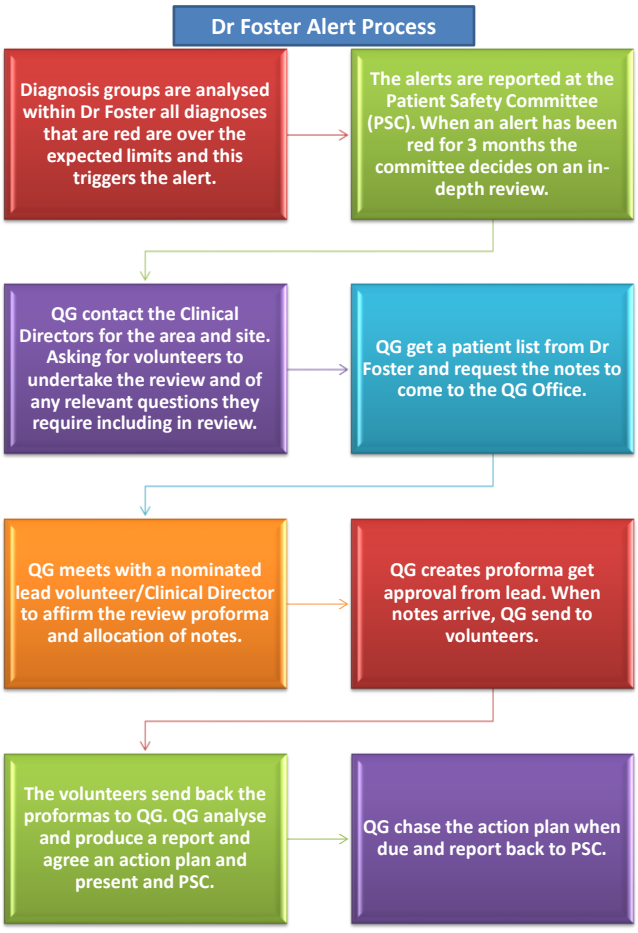
9.2 A high HSMR or persistent trend is a signal for further investigation. A range of other information should be used to determine if there is a genuine quality problem and where to look further.

9.3 Any of the following scenarios, should be used as triggers for investigating a high mortality rate:

1. A red alert on the mortality monitoring system (currently Dr Foster)
2. Higher than the national mortality benchmark of 100
3. A low confidence interval of above 90 is an indication of a possible alert and will be monitored.

9.4 In the event of an alert for 3 consecutive months, Patient Safety Committee will agree the approach to be taken to investigate the alert.

9.5 Dr Foster Alert Process:



10. Investigating Alerts

10.1 There are a number of reasons for an alert and the following process should be used to investigate:

- Check coding: for example there may be no or poor co-morbidity coding or incorrect coding for palliative care patients
- Casemix: consider if there has been an increased number of very sick patients
- Structure: for example are there problem related to the provision of end of life care in the community.
- Review the proformas already completed as part of the ongoing mortality review of all deaths at ULHT.
- Patient Safety Committee will endorse a case note review/audit to assess if there are issues relating to the quality of care. It will be recommended that the case notes are audited against the care pathway for the diagnosis which is alerting to establish whether or not the patients received care in line with the pathway.

10.2 Junior doctors are encouraged to participate in the alerting reviews to establish a culture of learning and enable involvement in the improvement journey.

10.3 A report to be generated indicating recommendations and these reports to be reviewed at the patient safety committee and site mortality meetings.

10.4 Women and Children's directorate complete IR1's for all mortalities and a full investigation is completed and is reported to Patient Safety Committee.

11. Quality Governance Department

11.1 A register of the reviews in progress and completed reviews will be kept by Quality Governance Department.

11.2 The Quality Governance Department will provide the reviewers with the notes and a mortality review proforma. The Review Form is appended (Appendix A).

11.3 The Quality Governance Department will seek assurance from the Clinical Directors that reviews are being undertaken and where appropriate actions are being taken to address areas of concerns arising from reviews. Quality Governance monitor the review compliance and it is escalated to Patient Safety Committee.

11.4 The Quality Governance Department will get the patient list and facilitate the casenotes and develop in-depth proforma alongside the named Lead Clinician for the investigating alerts.

11.5 Quality Governance will write the monthly Trust Mortality Report and Quarterly MoRAG and Lincolnshire Mortality Collaborative assurance reports governed by the Patient Safety Committee.

11.6 Quality Governance will ensure that all Learning Disability mortalities are reported to the LeDeR programme. Coding as advised by the LeDeR programme: F81.9 - Developmental disorder of scholastic skills, unspecified.

11.7 Women and Children's Clinical Directorate report mortalities through MBRRACE-UK. All mortalities within the Women and children's Clinical Directorate are investigated.

12. Reporting Process

12.1 The Quality Governance Department will produce and circulate the following reports

- Monthly reporting will include site level information, mortality review completion compliance, HSMR & SHMI, mortality alerts, Learning from Deaths National Template, Learning Disabilities and Mortality Reduction Plan. The report format is Appendix B and Learning from deaths template is Appendix F.

12.2 The Trust mortality report forms part of the Quality Report presented at the Quality Governance Committee.

12.3 The Quality Report is reported upward to Trust Board presented by the Medical Director and Non-executive Director.

12.4 Learning Disabilities are reported within the Trust Report and to the LeDeR Programme.

12.5 Women and Children directorate will report into the Patient Safety Committee Quarterly which will report upwardly to Quality Governance and Trust Board.

12.6 Where valuable lessons are learned from mortality reviews and where there are lessons which could be of benefit to patient's care they will be shared throughout the trust via the speciality governance meetings, Clinical Directorates and Patient Safety Committee.

12.7 Case note reviews with significant learning and good practice from MoRAG reviews will be produced in the monthly MoRAG Case Review Briefing. Circulated through the Trust communications and to the relevant forums.

12.8 Mortality general lessons, themes and good practice will be produced in the monthly Mortality Matters Briefing. Circulated through the Trust communications and the relevant forums.

12.9 Mortality is reported annually within the Quality Account.

13. Supporting Staff

13.1 There will be support available by their peers and senior managers for staff affected by the death of someone who has been in the trust's care.

13.2 There will be opportunities for staff to reflect on the care provided to people who have died and any learning from this to inform their practice and the way that care is organised.

14. Bereavement Services

14.1 There is a Bereavement Service available in Lincoln (located in the Swanpool Suite) and Pilgrim (located in the Chapel) so families and cares do not have to go to the ward where their loved ones have passed away. This provides a comforting and supportive place for the relatives and carers.

14.2 The Bereavement Service will provide help, advice and support to guide the families through the bereavement period. (Appendix F Leaflet for Bereaved Families.)

14.3 The Bereavement Service will discuss with the families and carers the care their loved ones had during their inpatient stay.

14.4 The Bereavement service will highlight to Quality Governance any concerns that have been raised by the family to enable an appropriate review to be conducted.

14.5 The Bereavement Service will also inform Quality Governance if there has been a patient with a Learning disability, a Mental Health diagnoses or any death referred to the Coroner as this will form part of the "Must Do Reviews" that Quality Governance facilitate.

14.6 The service will provide one place for the bereaved family to collect the patients belongings and death certificate issued.

References

- Dr Foster intelligence (2014) A toolkit on Hospital Standardised Mortality Ratios July 2014
- Department of Health (2010) National review of hospital standardised mortality ratios (HSMR)
- Department of Health (2010) NHS Outcomes Framework 2011/12
- The Association of Public Health Observatories (2011) Dying to Know
- National Quality Board (2017) National Guidance on Learning from Deaths
- University of Bristol: School for Policy Studies: Learning Disabilities Mortality Review (LeDeR) Programme
- National Perinatal Epidemiology Unit: MBRRACE-UK

Equality Analysis: Initial Assessment Form

Title: *of the function to which the Equality Analysis Initial Assessment applies*
Learning from Deaths – Mortality Review Policy

Describe the function to which the Equality Analysis Initial Assessment applies:		
☐ Service delivery	☐ Service improvement	☐ Service change
☐ Policy	☐ Strategy	☑ Procedure/Guidance
☐ Board paper	☐ Committee / Forum paper	☐ Business care
☐ Other (please specify) ……		

Is this assessment for a new or existing function?	**Yes**
Name and designation of function Lead professional:	**Neill Hepburn, Medical Director and Penny Owston Non-executive Vice Chair**
Business Unit / Clinical Directorate:	**Medical Directorate**

What are the intended outcomes of this function? (*Please include outline of function objectives and aims):* *Procedure for the completion of Mortality Reviews and guidance of learning from deaths, reporting Structure.*		
Who will be affected? Please describe in what manner they will be affected?		
Patients / Service Users:	**Staff:**	**Wider Community:**
	Procedure for the completion of Mortality Reviews and guidance of learning from deaths	

What impact is the function expected to have on people identifying with any of the protected characteristics (below), as articulated in the Equality Act 2010? (Please tick as appropriate)

	Positive	Neutral	Negative	**Please state the reason for your response and the evidence used in your assessment.**
Disability		☑		
Sex		☑		
Race		☑		
Age		☑		
Gender Reassignment		☑		
Sexual Orientation		☑		
Religion or Belief		☑		
Pregnancy & Maternity		☑		
Marriage & Civil Partnership		☑		
Carers		☑		
Other groups identified (please specify)		☑		

If the answer to the above question is a predicted negative impact for one or more of the protected characteristic groups, a full Equality Analysis must be completed. (The template is located on the Intranet)

Name of person/s who carried out the Equality Analysis Initial Assessment:	**Karen Moon**
Date assessment completed:	**27/09/2017**
Name of function owner:	**Bernadine Gallen**
Date assessment signed off by function owner:	**27/09/2017**
Proposed review date (please place in your diary)	**01/10/2019**

As we have a duty to publicise the results of all Equality Analyses, please forward a copy of this completed document to tim.couchman@ulh.nhs.uk.

Appendix A Mortality Proforma

Mortality Review proforma_Aug 17.xlsı

Appendix B Monthly Report

Mortality Report Sep 2017_PSC_V2.docx

Appendix C MoRAG Terms of Reference

Mortality Review Assurance Group (Mo

Appendix D Lincolnshire Collaborative Terms of Reference

Lincolnshire Mortality Collaborative Terms c

Appendix E Standard Operating Procedures

Dr Foster Alert Process.ppt

Lincolnshire Mortality Collaborative Process

Mortality Review Assurance Group (Mo

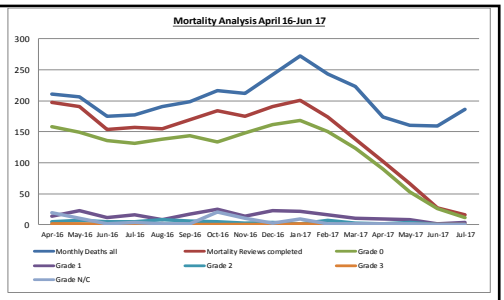
Appendix F Leaflet for Bereaved Families

2602 Information and advice following y

Appendix G Learning from Deaths Template

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable Grade 2&3	
This Month-Jul 17	Last Month-Jun 17	This Month-Jul 17	Last Month-Jun 17	This Month-Jul 17	Last Month-Jun 17
186	159	16	27	0	0
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
493	738	16	195	6	12
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
679	2566	211	2086	6	64



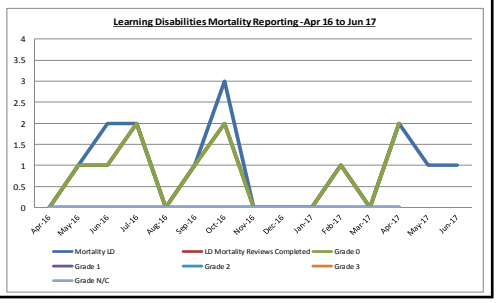
Review Grading

Grade 0		Grade 1		Grade 2		Grade 3		Grading not completed	
Unavoidable death, no suboptimal care		Unavoidable death, suboptimal care but different management would NOT have affected outcome		Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)		Not completed in proforma by reviewer	
This Month-Jun 17	96%	This Month-Jun 17	4%	This Month-Jun 17	0%	This Month-Jun 17	0%	This Month-Jun 17	0%
This Quarter (QTD) (Apr 17-Jun 17)	87%	This Quarter (QTD) (Apr 17-Jun 17)	9%	This Quarter (QTD) (Apr 17-Jun 17)	3%	This Quarter (QTD) (Apr 17-Jun 17)	0%	This Quarter (QTD) (Apr 17-Jun 17)	1%
This Year (YTD) (Apr 17-Jul 17)	86%	This Year (YTD) (Apr 17-Jun 17)	10%	This Year (YTD) (Apr 17-Jul 17)	3%	This Year (YTD) (Apr 17-Jul 17)	0%	This Year (YTD) (Apr 17-Jul 17)	1%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable Grade 2& 3	
This Month-Jun 17	Last Month-May 17	This Month-Jun 17	Last Month-May 17	This Month-Jun 17	Last Month-May 17
1	1	0	0	0	0
This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)	This Quarter (QTD) (Apr 17-Jun 17)	Last Quarter (Jan 17-Mar 17)
4	1	2	1	0	0
This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)	This Year (YTD) (Apr 17-Jul 17)	Last Year (Apr 16-Mar 17)
6	10	2	8	0	0



Signature Sheet

Names of people consulted about the document:

Name	Job title	Department
Patient Safety Committee		
Neill Hepburn	Medical Director	

Names of committees required to approve the document:	Approved on
Patient Safety Committee (Version 4)	September 2017
Clinical Effectiveness Steering Committee (Version 4)	Chair of CESC 28 September 2017