Mortality Review Policy

(CP32 0717)

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Ratified by:	Patient Safety and Experience Group (PSEG)/ Clare Hawkins, Deputy Chief Executive, Director of Quality and Chief Nurse
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Name and designation of Lead Policy Author:	Dr John Omany. Medical Director
Name of responsible Committee/ Individual:	Mortality Review Group/ Dr John Omany, Medical Director
Name of Executive Lead	Dr John Omany. Medical Director
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Target audience:	All Hertfordshire Community Trust (HCT) Staff

Name and Reference No. of Policy:
Mortality review policy, CP32 0717

Version: 1

Lead Author: John Omany

Exec Director: John Omany

Who is this document applicable to: All HCT staff

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Other policies that this policy should be read in conjunction with:

- HCT Serious Incident Policy
- HCT Being Open and Duty of Candour Policy
- HCT Standard Operating Procedure for mortality review for Community hospitals
- HCT Adults Safeguarding Policy and Procedure

Scope / Aim / Purpose:

The purpose of this policy is to describe the framework for reviewing all incidents of patient mortality.
This policy applies to all employees working within the Trust.

Key Component / Main content of the Policy:

The purpose of this policy is to ensure the Trust/ HCT complies with the requirement to -

1) review and investigation of patient deaths that occur in its care
2) to understand which problems in care might have contributed to the deaths in order to prevent recurrence
3) to ensure that learning is shared and acted upon

General Procedure guidance: Explained in Section 6 of this policy.

Specific procedure for individual groups: As explained in Section 5 of this policy.

Specific training info for staff: Training will be provided to relevant staff in the use of the Structured Judgement Case Note Review (SJCNR) methodology.

General info for equipment: NA

Governance & Escalation:

1) The Mortality Review Group (MRG) will hold quarterly meetings and have agreed terms of reference.
2) A quarterly assurance report, including the minutes of meetings will be sent to the PSEG, Healthcare Governance Committee (HGC) and the Trust Board.
3) The MRG will provide an Annual report to the Trust Board.

Contents

1. Introduction

1.1 Approximately 500,000 deaths are registered in England each year. Of these, about 47% occur in hospital, with the rest dying while receiving services provided by NHS Trusts as an outpatient or from community services. Recent investigations and reports have highlighted the importance of reviewing how care is delivered to dying people including the experience of their family and carers. It has become increasingly important for Trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality.

1.2 The CQC report: Learning, Candour, and Accountability (2016) identified inconsistencies in: the process of identifying and reporting the death; how decisions to review or investigate a death were made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions. In March 2017 the National Quality Board published its guidance on Learning from Deaths which provides a framework for identifying, reporting, investigating and learning from deaths in care.

1.3 Since the 1990s, there have been a number of reports and case studies which have consistently highlighted that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people.

1.4 Death is one, if not; the most significant event in a person's life and broadly falls into one of two sets of circumstances:

- Expected
- Unexpected

It is therefore essential to review incidents of mortality as appropriate to:

- Assess if patient death in NHS Care was avoidable and
- Review the quality of care nearing or at the time of death

1.5 It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. However, it is important that any opportunity for learning from deaths and learning from the review of care provided are not missed. This includes reviewing services provided in the period prior to the person's death to provide assurance that safe and effective care was delivered enabling a decision to be made on the need for further review. The rationale and justification for further review must be clearly documented.

1.6 Mortality reviews are a key component of demonstrating effective and safe patient care.
Whilst mortality reviews have traditionally been held within acute NHS organisations, they have not been routinely held in all NHS provider organisations including NHS services delivered in the community. The Francis Report, expectations from NHS Improvement and the Care Quality Commission (CQC) describe the process of mortality reviews as a key part of reviewing patient outcomes and working towards a high quality service.

1.7 This policy confirms the process to ensure a consistent and co-ordinated approach for the review of inpatient deaths within the HCT community hospitals. The policy includes the review of incident reports of unexpected community deaths or any statutory reporting of service user deaths.

Deaths that occur within the justice environment will be reviewed under health and justice process. Report findings and recommendations will be reported to the mortality review panel.

1.8 A consistent and coordinated approach for the review of all deaths within community hospitals is an important part of the Trust's commitment to maintaining high quality services, supporting staff and maintaining public confidence.

1.9 This policy sets out the procedures for reporting, reviewing and investigating deaths of people who have been in receipt of services from the Trust. It provides staff with information in relation to which deaths should be reported internally on the Trust's incident management system (Datix), subsequent review and the level of investigation that is required.

2.0 This policy supports the Trust's commitment to:

- Promoting a culture that assures the safety of patients.
- Promoting behaviours that support openness, transparency and demonstrate candour.
- Complying with regulatory requirements relevant to the business of the organisation.

2.1 This policy should be read in conjunction with the following HCT policies, guidelines and SOPs, documents/ forms available via the HCT intranet:

- HCT Serious Incident Policy
- HCT Incident Policy and Procedure
- HCT Being Open and Duty of Candour Policy
- HCT Standard Operating Procedure for mortality review for Community hospitals
- HCT Adults Safeguarding Policy and Procedure

2. Aim and Purpose

2.1 The aim of this process is to identify any areas of practice both specific to the individual case and beyond, which could potentially be improved. Areas of good practice are also identified and supported.

2.2 The policy will also aim to ensure:

- The output of reviews are clearly documented, linked to any incident reports and archived.
- Improved speed of response to concerns.
- An open and transparent learning culture.
- Presentation of regular quarterly reports to the Trust Board in addition to an annual report in the Quality Accounts report.

2.3 The purpose of this policy is to ensure that there are clear auditable reporting mechanisms in place, to escalate any areas of concern identified:

- To the clinicians/ service or locality managers concerned; and
- The appropriate Committees through to the Trust Board so that they are aware and can take appropriate action

2.4 The principle objectives of this policy are:

- To describe the framework for reviewing all incidents of patient mortality.
- To review all incidents of death and ensure appropriate review has taken place to assess if death was avoidable
- Review the quality of care at or near the time of death to ensure patient safety and high quality care was provided.
- To focus on deaths reported and investigated as Serious Incidents.

- To ensure actions are taken and learning shared to improve the safety and quality of patient care.
- To ensure the Trust is open and transparent when reviewing deaths in line with HCT Being Open and Duty of Candour Policy while disclosing incidents of poor care and avoidable deaths.

3. Scope

3.1 This policy is applicable to all staff working for, or on behalf of, the Trust (HCT) which includes all bank and agency staff.

3.2 HCT/ The Trust will select the following for review:

- All inpatient deaths

- Community deaths where:
  - The bereaved or staff raise significant concerns about the care.
  - The learning will inform quality improvement work.
  - The patient has died within 30 days of being discharged from a HCT community hospital.

Note - deaths occurring in the community within 30 days of discharge from acute hospitals are reviewed by the acute hospitals.

  - An alarm has been raised concerning a particular speciality, diagnosis or treatment group
  - The death is unexpected and HCT has had recent contact within seven days

Deaths of community patients with learning disabilities (LD) will be reviewed as part of Hertfordshire's Learning Disabilities Mortality Review (LeDeR) programme. For community patients with LD under the care of HCT at the time of their death, findings from the LeDeR review will be considered by HCT to identify learning.

3.3 The Mortality Review Process will include reviews on:

- All Serious Incidents relating to the care of deceased patients – these are expected to be identified by incident reporting
- All cases subject to an Inquest.
- Mortality or End of Life related complaints.

4. Explanation of Terms and Definitions

4.1 ***Mortality -*** For the purpose of the Mortality Review Group meetings, mortality relates to any deaths within 30 days of any surgical procedure or any in-hospital death for non-surgical specialties and community deaths where patients were in receipt of trust services.

4.2 ***Serious Incident (SI) -*** An accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death.

4.3 ***Avoidable/ Preventable -*** These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done to change the outcome.

4.4 ***Mortality Review Group (MRG) -*** A multi-disciplinary group that reviews and discusses clinical cases, outcome data (clinician and patient reported) and related information.

4.5 ***Mortality Review -*** The process of reviewing the quality of care and assessing if the incident of patient death was avoidable and to identify and if there was any learning.

4.6 ***Patient Safety incident -*** Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to patients as defined in the HCT Incident Policy and Procedure

4.7 ***Duty of Candour -*** is defined in The Francis report as "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

4.8 ***Being Open -*** Described by the National Patient Safety Agency in 2009 as: "discussing patient safety incidents promptly, fully and compassionately' adding that this 'can help patient and professionals to cope better with the after effects".

4.9 ***SystmOne -*** IT system used in HCT to record patient care

4.10 ***Expected/ anticipated death -*** A death where a patients demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death)

4.11 ***Unexpected/ unanticipated death*** - Any death not due to terminal illness, or a death the family was not expecting. It will also apply to patients where the GP has not attended within the preceding 14 days. Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an unexpected death.

4.12 ***Structured Judgement Case Note Review (SJCNR) –*** the accredited mortality review process tool which HCT has agreed to use to review deaths across the Trust.

4.13 ***Datix –*** Risk management tool used in HCT to report and investigate all incidents.

5. Ownership, Roles and Responsibilities

The generic statement of roles and responsibilities are in line with the HCT (Trust) GR1 1215 V.4. Roles and responsibilities specific to this particular policy are defined below.

5.1 Designated Committee

5.1.1 'Patient Safety and Experience Group (PSEG)' is the designated ratifying Committee for this policy.

5.2 Lead Executive Director

5.2.1 The 'Medical Director' is the identified Lead Executive Director for this policy.

5.3 Lead Policy Author

5.3.1 The identified Lead Policy Author for this policy is the 'Medical Director (MD)'.

5.3.2 The MD is responsible for ensuring that there is a comprehensive mortality policy, ensuring that all incidents of mortality are appropriately reviewed and where required appropriate actions are taken and learning disseminated.

5.3.3 The Medical Director will take lead responsibility for the development and implementation of this policy and in providing an overarching framework.

5.3.4 The Medical Director will also:

- Assure the Board that the Mortality Review Process is functioning correctly.
- Ensure that arrangements are in place so that all clinical staff as appropriate

are aware of their responsibilities to contribute to the process.
- Offer advice to colleagues involved with the review process.
- Chair the Trust's Mortality Review Group (MRG)

5.3.5 The Medical Director has overall responsibility for ensuring deaths within the Trust are monitored, reviewed, and any actions required identified and acted upon.

The Medical Director will act as chair of Mortality Review Group. In times of their absence, the Associate Medical Director has responsibility for reviewing cases, providing leadership and deputising as chair of the MRG.

5.4 Line/ Locality Managers/ Heads of Service

5.4.1 Are responsible for ensuring there are arrangements for reviewing all incidents of patient mortality.

5.5 Clinical Reviewers

5.5.1 Are responsible for:

- Completion of the in-patient Mortality Review Checklist as soon as possible or at the latest, within 7 days of the patient's death.
- When completing the Mortality Review Checklist the HCT Standard Operating Procedure for mortality review for Community hospitals should be followed.

5.5.2 For patients under the care of HCT who die in the community, all staff must inform their line manager when it comes to their attention that a patient has died; in order for the line manager to make arrangements to commence the mortality review process if it is appropriate.

5.6 Specialist Groups/ Individuals

5.6.1 ***Mortality Review Group (MRG) -*** The HCT MRG will meet on a quarterly basis and is responsible for:

- Ensuring the delivery of the Mortality Review Policy on behalf of the Healthcare Governance Committee (HGC).
- Attending quarterly review meetings, ensuring appropriate attendance by all relevant disciplines and professional groups.
- Identifying themes and areas of concern and putting corrective actions or preventative measures into the place.
- Reviewing and monitoring quarterly trend figures to ensure that possible adverse trends are discussed and undertake further investigation where this is indicated.
- Escalating when considered appropriate learning & action points to HGC.
- Producing minutes and reports
- The correct Governance of investigation of unexpected deaths
- Reviewing of all deaths reported in the prior month
- Identifying if there was a lapse in care which contributed to a death
- Recommending to the Medical Director and Chief Nurse if any of the deaths require any further investigation
- Reporting quarterly to the identified committees and the Trust Board and providing assurance about mortality review process
- Promoting learning from themes arising from the review of deaths using the Sharing Lessons in Practice approach.

5.6.2 ***Community & Inpatient Staff -*** are responsible for ensuring the Trust's SystmOne is accurately maintained in real time with relation to the following:

- Community caseloads
- Inpatient admission and discharges
- Referrals

All deaths within inpatient or community settings must be correctly recorded on each clinical team designated SystmOne:

- Inpatients: Discharged - 'Patient Died'
- Community caseload: Discharged - 'Patient Died'

5.6.3 ***Ward Managers/ Service Managers –*** are responsible for undertaking local case note reviews for expected deaths, involving relevant staff, liaising with the Patient Safety Team and Medical Director as needed.

They are also responsible for alerting line managers and the Patient Safety Team to all unexpected deaths and providing further information as requested.

5.6.4 ***The Associate Medical Director*** will attend the Mortality Review Group and in the absence of Medical Director may be asked to chair the MRG meetings.

6. Methodology & Procedure on 'Learning from Deaths'

6.1 This policy is aligned to NHSI's 'National Quality Board guidance on Learning from Deaths', published in March 2017 which states, 'community Trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted in problems in care. Trust should also ensure that they share and act upon any learning derived from these processes.'

6.2 The principle objectives of 'learning from deaths' are to ensure that:

- Deaths are appropriately reviewed to assess if there is potential for organisation to learn and share the learning.
- There is a consistent approach to mortality reviews and all deaths are reviewed using the agreed organisational screening tool by trained senior registered clinicians.
- There is a compassionate and professional engagement with patients' families when death occurs and when a death is reviewed.
- The review and investigation of deaths will adopt principles of openness and transparency, and learning rather than blame.
- The review and investigation of deaths will include the involvement of families and those close to the deceased where this is possible and appropriate. This includes (but is not limited to) the Trust Duty of Candour.
- Learning from deaths is a key priority for the Trust Board, with an identified senior clinical executive and non- executive lead.

6.3 HCT will adopt a proactive, proportionate approach to learning from mortality across the services delivered by the Trust. The Trust uses an accredited mortality review tool The Structured Judgement Case Note Review (SJCNR) process to review deaths.

Appendix 1 gives an outline of the Structured Judgement Case Note Review process.

6.4 All inpatient deaths will be screened using Mortality Review Trigger tool (MRTT) and reviewed using the SJCNR method within a month.

6.5 Community patients will also be receiving services from their GP and primary care team and may be receiving care from the other NHS and non NHS providers in Hertfordshire or elsewhere.

The focus of the mortality review for the community teams should be based on the care the patient received from HCT. Whilst undertaking the review, the reviewing team may observe issues that might have led to an avoidable death by another provider;

these should be reported on Datix. The provider will be informed of the findings and any lessons learnt from the incidents will be shared with them.

6.6 All incidents of suboptimal care should be reported on the Datix.

6.7 Deaths will be categorised using the 'Avoidability of death' scale as below :

Avoidability of Death 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

Where a mortality review concludes a score of 1, 2 or 3, the incidents of suboptimal care should be reported and investigated as a Serious Incidents.

6.8 Appendix 3 details the agreed terms of reference for HCT Mortality Review Group.

7. Patients Who Die in the Community while in the Care of HCT

7.1 For all patients living in the community who die whilst in the care of HCT:

- Community contacts range from seeing one HCT Health Care Professional, (HCP), once every few months to weekly or even daily contact with a range of HCT staff. Community patients will also be receiving services from the primary care team and may be receiving care from other NHS and non NHS providers in Hertfordshire or elsewhere.
- The focus of the mortality review for community teams should be based on the care the patient received from HCT.
- The review and investigation of deaths will adopt principles of openness and transparency, and learning rather than blame.
- The review and investigation of deaths will include the involvement of families and those close to the deceased where this is possible and appropriate.
- The Trust is committed to the involvement of families and carers when reviewing or investigating the circumstances that lead to a death, and in any learning that results from that investigation. This includes (but is not limited to) HCT Duty of candour.
- This should include informing the family/ carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/ carers will be involved to the extent that they wish to be involved. Initial contact with families/ carers is often managed by the clinicians responsible for the care of the patient. Consideration is to be given as to whether an independent third party should undertake this role.
- Offer guidance, where appropriate, on obtaining legal advice for families, carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.
- The reviewers are to determine and inform any service within the organisation about the death and any other organisation who may have an interest, including the deceased persons GP.

7.2 All inpatient deaths and community deaths within scope will be logged on Datix immediately.
The Datix entry should include the outcome of the screening review i.e. case closed or further in-depth review carried out.

7.3 It is now ***mandatory*** in incidents reported in Datix to record whether the patient who has died has a learning disability or mental health issues.

7.4 If categorised as a potential Serious Incident (SI) the unexpected deaths will follow the process as detailed in the Trust's HCT Serious Incident Policy.

7.5 The service will also commence the Mortality Review process using the SJCNR and notify the family that a review is under way.

The SJCNR process will be used in all cases and will supplement other SI documentation, NOT replace it, NOR be replaced by it.

All reviews of mortality must be reviewed against the Trust's policies and procedures.

7.6 When reporting the event on Datix, the reporter must identify if the death was 'expected' or 'unexpected'.

Definitions of ''expected' and 'unexpected' are outlined in Section 4.

7.7 In line with the HCT Incident Policy and Procedure, the unit/service where the death occurred must ensure that their senior manager is informed of the death. The senior manager will ensure that protected time is provided for staff who are involved in the Mortality Review process.

7.8 For adult deaths in community hospitals that were expected, the senior clinician on the ward, usually the Ward Manager, must complete a 'Mortality Case Note Review' checklist within 7 working days and return the completed checklist to the HCT Patient Safety Coordinator who will make arrangements for the case notes to be delivered to the HCT Headquarters, Howard Court (Appendix 2).

7.9 The Patient Safety Team will ensure that the Medical Director/ Associate Medical Director receive and are able to review the completed checklists. The Medical Director/ Associate Medical Director will make decisions based on the individual case, including for example, requesting further information, scheduling the death to be reviewed at the next Mortality Review Group, convening an extra-ordinary Review meeting or confirming the death should be reported and investigated as a serious incident.

7.10 The Mortality Review Group is established and works to agreed Terms of Reference (TOR), as per Appendix 3.

7.11 All deaths occurring under the care of HCT will be reviewed by the Group who will provide a written summary of the discussion and the conclusions reached, including identifying any learning points and actions that are to be taken.

7.12 The Chair of the Mortality Review Group, will ensure lessons and actions are disseminated to those who are responsible for their implementation.

8. Mortality Review Process for Patients with Learning Disabilities

8.1 HCT participates with the LeDeR (Learning Disabilities Mortality Review) programme

which is an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

Across Hertfordshire the Hertfordshire County Council Lead (HCC lead) coordinates the LeDeR programme in which HCT participates along with other care providers and agencies. The HCC Lead also coordinates the review of people with learning disabilities who die, including those people who die who are known to HCT.

The deaths of all people with a learning disability (age 4 and over) will be part of the LeDeR programme.

All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

8.2 The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

8.3 A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas.

A full multi-agency review is recommended-

- if there have been any concerns raised about the death,
- if any 'red flag alerts' have been identified in the initial review, or
- if the reviewer thinks that a full multi-agency review would be appropriate.

The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

8.4 The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

9. Mortality Review Process for Children, Young People (CYP) and Families

9.1 All child deaths are recorded on Datix at the time the service becomes aware of the death. If a child death occurs and the child/ young person is not known to the HCT children's services, the safeguarding nurses will report this on Datix.

9.2 A process of analysis and learning then follows, whether this is as part of wider system external review processes, or through our own internal processes. HCT processes are designed to complement the inter-agency Child Death Overview Panel (CDOP) processes, including the Serious Case Review process.

10. Mortality Review Process for Bereaved families and Carers

10.1 Bereaved families and carers:

- should be treated as equal partners following a bereavement
- must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support
- should be informed of their right to raise concerns about the quality of care provided to their loved one
- views should help to inform decisions about whether a review or investigation is needed
- should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison
- should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations
- who have experienced the investigation process should be supported to work in partnership with other Trusts in delivering training for staff in supporting family and carer involvement where they want to.

11. Implementation and Training

11.1 The policy will be made available for reference for all staff at all times and the Trust (HCT) will ensure all staff implementing this policy have access to appropriate implementation tools, advice and training.

11.2 The implementation of this policy will be monitored against the following:

- Quarterly reporting of the Mortality Review Group (MRG) to PSEG and the HCG committee and the Trust Board,
- Appropriately review of all incidents of mortality
- Evidence that there is a focus and analysis on all incidents of mortality investigated under the HCT Serious Incident Policy
- Assurance from the MRG that actions have been completed and learning shared
- Benchmarking Trust incidents of mortality with similar NHS organisations.

11.3 All staff that provide patient care should have an awareness of this policy. This can be supported by being trained in using the Mortality Review Trigger Tool in collaboration with the HCT Learning and Development team, for those staff where this is relevant.

11.4 10 to 15 members of staff from across the inpatient units and community teams will be trained in the Structured Judgement Case Note Review (SJCNR) methodology.

12. Monitoring Compliance and Effectiveness of Policy

12.1 All incidents within the scope of this policy must be reported and managed in accordance with the HCT Incident Policy and Procedure and the HCT Serious Incident Policy.

12.2 The Key Performance Indicators (KPI) for this policy are that:

- The MRG will hold quarterly meetings and have agreed Terms of Reference.
- A quarterly assurance report including any data regarding number of deaths and classification assigned to them, as well as on request, the minutes of the meetings, will be sent to the PSEG, HGC and the Trust Board.
- The MRG will provide an Annual Report to the HCT Board/ and in the Quality Account.

13. Review, Revision and Governance

13.1 The review, updating and archiving process for this policy shall be carried out in accordance with the Trust (HCT) GR1 Policy for Procedural Documents, V.4 by the identified Lead Policy Author.

13.2 The version control table (Appendix 4) enables appropriate control of the policy with listed personnel responsible for its implementation as well as the date assigned/ approved/ circulated.

13.3 ***Information Governance -*** The minutes of the MRG will summarize the discussion taking place at the meeting, including outcomes of individual reviews.
The reports concerning individual cases and discussion relating to them are confidential and shall be exempt from requests under the Freedom of Information Act.

14. Equality Impact Analyses (EIA)

14.1 It is the responsibility of the Lead Policy Author to complete the EIA form (Appendix 5) before submitting the policy for ratification.

15. References

- Keogh B, Durkin M. Self-Assessment on Avoidable Mortality. Letter to NHS Medical Directors; 2015
- Worcestershire Health and Care NHS Trust Mortality Review Policy 2016
- Mazars Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015; 2015
- Staffordshire and Stoke on Trent Partnership NHS Mortality Review Policy 2016
- Central London Community Healthcare NHS Trust Policy on Learning from Deaths 2017
- HCT Serious Incident Policy
- HCT Incident Policy and Procedure
- HCT Being Open and Duty of Candour Policy
- HCT Standard Operating Procedure for mortality review for Community hospitals
- Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities
- National Quality Board published its guidance on Learning from Deaths
- CQC report: Learning, Candour, and Accountability (2016)
- HCT Adults Safeguarding Policy and Procedure

16. Appendices

The following appendices are attached to support this policy:

Appendix 1 – Summery of the structured judgement case note review

Appendix 2 – Community Hospital Mortality Review Checklist
Appendix 3 – Community Hospitals Mortality Review Group Terms of Reference
Appendix 4 – Version Control Table
Appendix 5 – Equality Impact Analyses Form

APPENDICES

Appendix 1: Summary of the Structured Judgement case note Review (SJCNR)

Background and Strengths

The Structured Judgement Review provides a standardised but flexible case note review method that is usable across services, teams and specialities.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions**.**

Stages of Review

There are two stages to the review process. The first stage is mainly the domain of what might be called 'front line' reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first- stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified.

Phases of Care –the 'structure' part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review section may only be required in a few medical cases (eg a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/ procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

Explicit Judgement comments- the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

The central part of the review process comprises short, written, explicit judgement statements about the perceived safety and quality of care that is provided in each care phase. Reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment. Explicit statements use judgement words and phrases such as 'good', 'unsatisfactory', 'failure' or 'best practice'.

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement. Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) and are given for each phase of care that is commented on and for care overall.

The Second Stage review

The second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient's death.

Judging the level of the avoidability of a death is complex, because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. The judgement is framed by a six-point scale (1 – definitely avoidable to 6– no evidence of avoidability).

The Avoidability of Death 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

A score of 1, 2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

Appendix 2: Community Hospital Mortality Review Checklist

FRONT SHEET - to be completed for all patients who die during admission

drop down box (only use the options available)

Location			
Unit		Ward	
Patient Details			
Patient Initials		Patient NHS No:	
DoB:			
Admission Details			
Date of Admission: dd/mm/yyyy		Day	Time:
Reason for Admission: (free text here)			
Date of Death dd/mm/yyyy		Day	Time:
Total number of Days on Unit:			days
Case Note Review			
Date of local, case note review dd/mm/yyyy			
Reviewer & Designation:			
Confirmed main diagnosis : (free text here)			
Cause of death (taking all information into account including post mortem)			
1a			
1b			
1c			
1d			

Was death the likely anticipated outcome of this admission?

YES		If YES Complete Form A
NO		If NO Complete Form B

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FORM A - to be completed when death was the anticipated outcome of the admission

Community Hospital Mortality Review Checklist

drop down box (only use the options available)

To be completed by ward/unit (eg Ward manager)

Key purpose of this review is to ensure all appropriate care was delivered in a timely manner.

Location			
Unit		Ward	
Patient Details			
Patient Initials	0	Patient NHS No:	0

Aspect of Care	Y/N	Supporting Comments **to be provided for all responses**
a. Was patient placed on EOL pathway?		
b. Was there evidence of a clear management plan?		
c. Was DNAR inplace?		
d. Was a timely referral made to palliative care and advice implemented?		
e. Was pain and suffering effctively controlled?		
f. Was delivery of care timely?		
g. Was communication with family well managed?		
h. Was communication between MDT well managed?		
i. Were spiritual needs considered/met?		
j. Was medication well managed?		
k. Were nutritional needs well managed?		
l. Were hydration/fluid management timely?		
m. Was skin care effectively managed?		
n. Was dignity maintained?		
Care after death		
o. Were the GP and referring doctor informed of the death?		
p. Were relative/the carer provided with information?		
q. In your opinion was there anything that could have been done differently?		
r. How do you think the quality of care might have been provided differently?		
s. Highlight any aspects of notable 'good quality' care		
t. In your opinion on a scale of 1 - 7 was the standard of documentation (1 = excellent - 7 = very poor)		

FORM B - to be completed when death was not the anticipated outcome of this admission

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GLOBAL TRIGGER TOOL

(Adapted for HCT Community Hospitals from the Institute for Healthcare Improvement, UK version)

Location			
Unit		Ward	
Patient Details			
Patient Initials	0	Patient NHS No:	0

General Care Module		No. of Events	Event Description	Severity E - I (see key overleaf)
G1	Lack of early warning score or early warning score requiring response			
G2	Any patient fall?			
G3	Pressure damage during hospitalisation			
G4	Re-admission to hospital within 30 days			
G5	Shock of cardiac arrest			
G6	DVT/PE following admission evidence by imaging +/- D dimmers			
G7	Complication of procedure or treatment			
G8	Transfer to Acute (higher level of care)			
Medication Module				
M1	Vitamin K			
M2	Naloxone			
M3	Flumazenil			
M4	Glucagon or 50% glucose			
M5	Abrupt medication stop			
Lab Test Module Haematology				
L1	High INR (>5)			
L2	Transfusion			
L3	Abrupt drop in Hb or Hct (>25%)			
Biochemistry				
L4	Rising urea or creatinine (>2 x baseline)			
L5	Electrolyte abnormalities (Na+ <120 or >160)			
L6	K+ (<2.5 or >6.5)			
L7	Hypoglycaemia (<3mmol/l)			
L8	Raised Troponin (>1.5 ng/ml)			
Microbiology				
L9	MRSA bacteraemia			
L10	*Clostridium Difficile* infection			
L11	Vancomyclin Resistant Enterococcus (VRE) infection			
L12	Wound infection			
L13	Hospital acquired pneumonia			
L14	Positive blood culture			
Total Number of Events				

The Trigger Tool helps to identify events which may have resulted in physical harm. These are categorised:	
Severity Category Key:	
E	contributed to or resulted in temporary harm to the patient and required intervention
F	contributed to or resultd in temporary harm to patients and required initial or prolonged hospitalisation
G	contributed to or resulted in permanent patient harm
H	required intervention to sustain life
I	contributed to the patient's death
The key aspects to be covered during this process are:	
*	Observations and nutrition/hydration charts
*	Blood/Laboratory reports
*	X-ray reports
*	Procedural Notes
*	Nursing Notes
*	Medical Notes
Additional comments / notes:	
Completed By:	
Name:	**Designation:**
Signature:	**Date:**

Appendix 3: Mortality Review Group Terms of Reference

1. TITLE & FORMATION

1.1 Community Hospitals Mortality Review Group

2. STATUS & DELEGATED AUTHORITY

2.1 The Community Hospitals Mortality Review Group (Mortality Review Group) is a sub-group of the Patient Safety & Experience Group (PSEG).

2.2 The Mortality Review Group is authorised to make decisions which are:

(i) Within these Terms of Reference

(ii) Specifically referred by the Patient Safety and Experience Group

2.3 Members of the Mortality Review Group have the delegated authority to undertake their duties on behalf of the area they are representing.

2.4 The Mortality Review Group will escalate risks it determines as appropriate, directly to PSEG and/or the Exec.

3. PURPOSE

The purpose of the Mortality Review Group is to reduce avoidable deaths and improve patient safety through:

3.1 Ensuring that the mortality review process as detailed in the Community Hospitals Mortality Review Standard Operating Procedure is adhered to, including review of all deaths that have occurred in all HCT community hospitals (adults).

3.2 Providing assurance on behalf of the Trust that the care delivered to patients before their death was of the expected standard and to identify both good practice and where care needs to be improved.

3.3 Making sure all identified learning is implemented into practice across all community hospitals.

4. DUTIES

Key duties of the Mortality Review Group shall include (but will not be restricted to):

4.1 Ensure all deaths occurring in community hospitals are reviewed.

4.2 Investigate any alerts received from the CQC or identified via other mortality monitoring systems.

4.3 Develop and maintain a data collection system to ensure the Trust's mortality data is timely, robust and available to support the identification of themes, trends, concerns and good practice.

4.4 Report on mortality performance and ensure the PSEG/ HGC and Trust Board is informed of mortality outcomes and trends.

4.5 Ensure that any risks or areas of concern are escalated in a timely way and that appropriate actions are taken.

4.6 Contribute to identifying any deaths that should be reported and investigated as a serious incident.

5. MEMBERSHIP & ATTENDANCE

5.1 The Mortality Review Group consists of the following core members:

1	Chair OR Deputy	Medical Director Associate Medical

2	Executive nurse	Chief Nurse and/or Deputy Chief Nurse
3	Medical representatives	Including for example, Senior Consultant PBCH, Associate Medical Director, GP providing care into community hospital
4	Clinical leads for community hospitals	Including for example Lead Nurse Community Hospitals, Advanced Nurse Practitioner and Lead Nurse Neurological Services.
5	Specialist palliative care representative	Including Consultant in Palliative Care or Clinical Quality Lead (Nurse) Specialist Palliative Care for HV or E&N business Unit
6	Clinical services manager for community hospitals	Including for example Deputy General Manager, Inpatients or Clinical Services Manager for Community Hospitals
7	Patient safety lead	Head of Patient Safety
8	Meeting coordinator	Patient Safety Coordinator

5.2 Co-opted attendees:

Additional, co-opted attendees will be identified prior to meetings and requested to attend for specific purposes which may include, drawing on specific areas of expertise, presenting information, discussing recommendations and agreeing actions. Additional attendees could include:

- Specialist medical representation
- End of life representation
- Locality/service managers
- Ward managers/matrons
- Clinical specialists
- Governance specialists

5.3 All core members will be invited to each meeting and co-opted members will be invited as appropriate, to meetings (or part thereof) for the specific expertise they bring.

5.4 Core members will send apologies if not able to attend the meetings and will arrange a suitable alternate to attend in their place, including ensuring their alternate is fully briefed and able to fully participate in the meeting.

5.5 Core members will be responsible for reporting back on activities of the group and lessons learned to their individual units

5.6 All members must adequately prepare for the meeting by reviewing the papers and provide effective challenge to the issues under discussion.

6. MEETINGS

6.1 Meetings will be held no less frequently than quarterly and more frequently as agreed by the Chair or Deputy Chair.

6.2 Additional and extra-ordinary meetings may be called at the discretion of the Chair or Deputy Chair.

6.3 Dates will be set with a minimum of one month's notice.

7. QUORUM

7.1 The Chair or Deputy Chair and at least 50% from the remaining core members group.

8. DECISION MAKING

8.1 The Mortality Review Group has joint and collective responsibility for agreeing decisions. Decisions shall be reached by consensus where possible, and matters that cannot be resolved will be escalated to the PSEG.

9. REPORTING ARRANGEMENTS

9.1 Within two weeks of each Mortality Review Group the Chair will complete and submit to PSEG a 'Chair's Assurance Report'.

9.2 The Mortality Review Group will provide reports to PSEG no less frequently than six-monthly.

9.3 A quarterly overview will be included within each quarterly Quality Report.

9.4 Evidence of lessons learnt and implementation of improved practice will be reported to the PSEG and HGC to demonstrate positive outcomes for patient safety.

10. RELATED MEETINGS & COMMITTEES

10.1 Accountable to the Patient Experience & Safety Group.

10.2 Integration and coordination with other groups overseeing the quality agenda in HCT via Healthcare Governance Committee.

11. TERMS OF REFERENCE – RATIFICATION AND REVIEW

11.1 The Terms of Reference will be ratified by the PSEG.

11.2 The Terms of Reference will be reviewed annually from date of ratification or earlier at the Chair's discretion.

Appendix 4: Version Control Table

Version No.	Status (Draft / Approved)	Date (mm/yyyy)	Circulation list	Comment (Key changes)
V.1	draft	August 2017	John Omany, Lead author	
V.1	Consultation draft	August 2017	John Omany	
V.1	Consultation draft	August 2017	Mortality Review Group which includes – Head of Patient Safety, Deputy CEO/Chief Nurse/ Director of Quality & Governance, Clinical Service Manager, Service Manager of Neuro, Ward Manager, Consultant, Team Leader, Patient Safety Coordinator, Deputy GM Inpatients, Associate Medical Director & Deputy Director of Quality and Governance	
V.1	Consultation draft	August 2017	PSEG members – Head of Risk and Clinical Effectiveness, Clinical Service Manager, Head of Patient Safety, Deputy CEO/Chief Nurse/ Director of Quality, Deputy Director of Quality and Governance, Lead Allied Health Professional, Carer in Herts Representative, Health Watch Herts Representative, Clinical Quality Lead Nursing, Equality & Diversity Manager, Deputy GM Nursing, Lead Infection and Prevention Control Nurse, Safeguarding Named Adult Nurse, Clinical Lead Bladder and Bowel Services, Head of patient Experience, CE Manager, Risk & Assurance Manager, Chief Pharmacist, Medical Device Manager, Tissue Viability Lead, Safeguarding Named Children Nurse and School Nursing and Visiting Lead	
V.1	Consultation draft	September 2017	Tracey Westley, Assistant Director Risk and Quality Assurance	
V.1	Approved	September 2017	Clare Hawkins, Director of Quality, Deputy CEO/ Chief Nurse	

Historical Editions: NA as new policy

Edition / Version and Date	Reason for archiving	Date for archiving and location

Appendix 5: Equality Impact Analyses Form

To be undertaken, completed and attached to any procedural document when submitted to the appropriate committee for consideration and ratification.

Function or Service (*name of the policy*)	Mortality Review Policy
Date of Equality Analysis	12/09/17
Those involved in this analysis	John Omany & Monika Kalyan

Intended Outcomes What are the Desired Outcomes? What are the benefits?	**Human Rights Approach** What are the patient's core rights as part of this service / function? Are there any gaps identified? What are the risks? What action is needed to mitigate risk and / or close the gap?
The Trust is committed to service improvement and acknowledges that systematic mortality review has a crucial part in delivering the clinical quality agenda and providing assurance of quality improvement. In view of this HCT intends to strengthen its record of systematically reviewing mortality.	This policy and procedure will be implemented consistently regardless of any such factors and all will be treated with dignity and respect.

Evidence What evidence is being used to support and develop the service / function?	**What are the Risks?** What are the risks in providing an equitable service? How can these risks be reduced, managed or justified?
HCT is committed to the fair treatment of all, regardless of age, disability, ethnicity, gender reassignment, religion or belief, sex, sexual orientation, marriage & civil partnership, pregnancy & maternity or any other personal characteristic. The focus is on ensuring HCT mechanisms for mortality review are strong and effective in protecting all patients from harm. We anticipate a positive impact on all groups.	None identified

Who will be Affected? Identify issues in relation to each of the protected groups below:	
Race: None	Gender Reassignment: None
Disability: HCT is participating in the LeDeR programme which aims to ensure that reviews of deaths lead to learning which will result in improved health services for people with learning disabilities. For community patients with LD under the care of HCT at the time of their death, findings from the LeDeR review will be considered by HCT to identify learning.	Religion or Belief: None
Gender: None	Maternity & Pregnancy: None
Age: None	Marriage & Civil Partnership: None
Sexual Orientation: None	

What Workforce Issues, including job role and design, need to be considered?	**Engagement and Involvement** Who has been involved in this analysis?
This policy sets out clear responsibilities for staff in relation to mortality review.	Monika Kalyan & John Omany

Actions Identified: None

S. No.	What	Who	When	Cost