<table>
<thead>
<tr>
<th>Title</th>
<th>OUH Mortality Review Strategy and Standardised Mortality Review policy following new guidance from NHS England and the National Quality Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>For information</td>
</tr>
<tr>
<td>History</td>
<td>The proposed revisions to the Standardised Mortality Review Policy have been presented at the Clinical Governance Committee on the 19\textsuperscript{th} July 2017, the Mortality Review Group on the 20\textsuperscript{th} July 2017 and Quality Committee on the 9\textsuperscript{th} August 2017.</td>
</tr>
<tr>
<td>Board Lead</td>
<td>Dr Tony Berendt, Medical Director</td>
</tr>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
</tr>
</tbody>
</table>
### Executive Summary

1. In December 2016 the Care Quality Commission (CQC) published Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England. The report found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more that the NHS can do to engage families and carers and to recognise their insights as a vital source of learning.

2. In March 2017 the National Quality Board published guidance based on the recommendations from the CQC report. A requirement was that Trusts develop and publish an updated mortality policy by September 2017.

3. In accordance with the new national guidance the OUH has put in place Board level leadership. The Medical Director will be the Board level lead who has delegated to the Deputy Medical Director. The Deputy Chair of the Trust and Chair of the Quality Committee will be the Non-Executive lead. Implementation is on a background of 56% of cases currently undergoing a more detailed level 2 review.

4. In accordance with the new national guidance the OUH Standardised Mortality Review Policy has been revised. This paper presents the background to the revisions to the OUH Standardised Mortality Review Policy and a summary of the changes to the policy. Key aspects of the new policy include the introduction of structured mortality review where specific criteria exist and proposals for ensuring concerns of families are heard. Additional guidance on child mortality review and the revised Standardised Mortality Review policy is provided in Appendix One to this paper.

5. The plan to implement this policy and expected numbers of review are described including training arrangements and risks. The Academic Health Science Network (AHSN) is looking to support network wide learning via a new group.

6. **Recommendation**
   The Board is asked to receive and discuss the mortality review strategy and revised Standardised Mortality Review policy.
Updates to the OUH Mortality Review Strategy and Standardised Mortality Review policy

1. Purpose
   1.1. This paper presents the background to the updates to the OUH mortality strategy and revisions to the Standardised Mortality Review Policy. A summary of the changes to the Standardised Mortality Review policy is provided.

2. Background
   2.1. In December 2016 the Care Quality Commission (CQC) published ‘Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England’. The report found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more that the NHS can do to engage families and carers and to recognise their insights as a vital source of learning.

   2.2. In March 2017 the National Quality Board published guidance based on the recommendations from the CQC report. The guidance requires that:
   2.2.1. mortality governance should be a key priority for Trust Boards
   2.2.2. an existing executive director should be identified as the patient safety director and a non-executive director should oversee progress
   2.2.3. each Trust develop and publish an updated mortality policy by September 2017
   2.2.4. mortality data must be collected from April 2017 on a quarterly basis and published from Quarter 3 2017-2018 onwards
   2.2.5. mortality data be summarised in Quality Accounts from June 2018 in accordance with changes to the Quality Accounts regulations
   2.2.6. a mortality surveillance group including multi-professional membership be in place
   2.2.7. reporting to the Board in public and communications with frontline staff about the outcome of investigations to share learning occur regularly
   2.2.8. there be three levels of scrutiny of deaths namely, death certification, case record review and investigation
   2.2.9. case record review should be robust Structured Judgement Review (methodology from the Royal College of Physicians) or other recognised approach
   2.2.10. reviews should be objective and by clinicians not involved in the care
   2.2.11. there be cross system reviews and investigations
   2.2.12. there is a clear policy for engagement with bereaved families and carers including giving them the opportunity to raise questions or share concerns in relation to the quality of care received.
3. **Trust Board responsibilities**

The Board should ensure that the Trust:

3.1. 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.

3.2. The Trust Vice Chair and Chair of the Quality Committee is the designated Non-Executive Director responsible for oversight of progress with the mortality guidance.

3.3. The Medical Director will be the Board level lead who has delegated to the Deputy Medical Director. The Deputy Medical Director is the Trust Management Executive (TME) level lead acting as Patient Safety Director with accountability for the learning from deaths agenda.

3.4. The Board should seek assurance from the attached policy and this paper that the policy:

3.4.1. pays particular attention to the care of patients with a learning disability or mental health needs;

3.4.2. has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;

3.4.3. adopts a robust and effective methodology for case record reviews of all selected deaths 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;

3.4.4. 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;

3.4.5. 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 with data suitably anonymised;

3.4.6. 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;

3.4.7. shares relevant learning across the organisation and with other services where the insight gained could be useful;
3.4.8. 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;

3.4.9. offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death;

3.4.10. 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,

3.4.11. 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.

4. Current process for mortality surveillance at OUH

4.1. Approximately 2500 patients admitted to our hospitals die each year. Many of these deaths are expected and are managed entirely appropriately.

4.2. The standardised mortality review policy requires the mortality review to be completed within 6 weeks of a death. Currently 89% of all deaths in the Trust are reviewed at either Level 1 and/or Level 2 within 6 weeks of occurrence.

4.3. Level 2 reviews occur where a concern or learning opportunity is identified in the Level 1 review and are not expected to apply to all patients. Some teams have elected to carry out level 2 reviews on all cases to maximise learning which means OUH approaches the new methodology with a clinical body highly engaged in mortality review. For the financial year 2016/2017 of the total number of inpatient deaths 56% (1573) had a Level 2 review completed.

4.4. OUH has a robust system for learning from deaths with each clinical division reporting quarterly to the Trust wide Mortality Review Group (MRG).

4.5. Teams in Surgery and Medicine have developed bespoke electronic databases for recording mortality reviews.

4.6. The Board receives regular updates on both numbers of deaths, risk adjusted metrics of mortality and the compliance with mortality review across the Trust.

4.7. OUH investigates some serious incidents in which the patient has died (whether the incident itself is causal or coincidental).
5. **Revisions to the mortality review policy**

5.1. There will be executive and non-executive oversight of the mortality review process as described above.

5.2. There is an expectation of increased involvement of bereaved families and carers in the mortality review process by:

   5.2.1. providing bereaved families and carers with the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

   5.2.2. working more closely with bereaved families and carers to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

   5.2.3. the bereavement team leading on liaising with all families

5.3. **Criteria for Structured Review:** The mortality review process will include a programme of structured review based on the Royal College of Physicians methodology. Structured review instead of a Level 2 review will be mandated in the following cases:

   5.3.1. Bereaved families and carers have raised a significant concern about the quality of care provision

   5.3.2. Staff have raised a significant concern about the quality of care provision

   5.3.3. Learning disabilities

   5.3.4. Severe mental illness (criteria established)

   5.3.5. Maternal deaths

   5.3.6. Serious Incident Requiring Investigation (SIRI) involving a patient death

   5.3.7. Mortality alerts from alerts for Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator

   5.3.8. Inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths”

5.4. NHS Improvement has informed the Trust that the structured review methodology will not apply to child deaths. The national mortality review process for children is due to be published at a later date. Currently child deaths have a Level 2 review completed by the responsible OUH team or where applicable the review is completed in accordance with the Child Death Overview Panel (CDOP) process.

5.5. The revised Standardised Mortality Review policy is provided in the Appendix to this paper.

6. **Reporting requirements**

6.1. From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths.
6.2. This should be through a paper and an agenda item to a Public Board meeting in each quarter to set out the Trust's policy and approach by the end of Q2 (this paper) and publication of the data and learning points (from Q3 onwards).

6.3. Quarterly data will be reported to the OUH Public Board meeting via the Board quality report mortality section and going forward will include an extract from the mortality dashboard (appendix two).

6.4. This will be prepared and managed by the clinical governance department and signed off by the Deputy Medical Director or Medical Director.

6.5. This data will include:
   6.5.1. the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts)
   6.5.2. those deaths that the Trust has subjected to structured review
   6.5.3. of those deaths subjected to structured review; the total number of deaths considered to have more than a 50% chance of having been avoidable
   6.5.4. the total number of inpatient deaths for patients with identified learning disabilities
   6.5.5. the total number of deaths of patients with identified learning disabilities considered to have been potentially avoidable

6.6. Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018.

6.7. It is noted that 17/18 will be partially compliant with this policy due to its introduction in Q3. It is not intended that retrospective reviews according to the new policy will be applied to deaths in Q1-2.

7. **Consultation on the revised mortality review policy**
   7.1. The Trust Mortality Review Group have been involved in reviewing the national guidance when first published and informing the revisions to the mortality review policy.

   7.2. The proposed revised mortality review policy has been distributed to the clinical divisions for review and feedback from the clinical teams during a 2 week consultation period.

   7.3. The revised policy was presented at the Clinical Governance Committee on the 19th July 2017 with Committee members providing feedback and recommendations.

   7.4. Separate meetings have been held with the bereavement team to discuss their role in seeking concerns from families.

8. **Training**
   8.1. The Royal College of Physicians (RCP) has led a process to provide training on the structured judgement review methodology.
8.2. The Deputy Medical Director and a Consultant Intensivist and Mortality Lead for ITU attended the first session in June 2017 and are now accredited cascade trainers.

8.3. The first OUH training for mortality review group members took place on 7/8/17. The Trust understands this is the first training on Structured Judgement Review (SJR) in the region.

8.4. A cascade of training has been scheduled during September and October for the mortality leads nominated by their Divisional Medical Directors.

8.5. The national RCP program has approached the Academic Health Science Networks (AHSNs) to co-ordinate training and peer support

8.5.1. Oxford AHSN are establishing a mortality group as part of the patient safety work stream

8.5.2. They have invited the Deputy Medical Director to chair the group with a clinical lead from another Oxford AHSN Trust.

8.5.3. The scope of the group may include a screening tool to identify deaths for SJR; support with delivery of SJR; regional/peer review of ‘borderline cases’ and when and how to inform families.

8.5.4. The first scoping meeting for the AHSN team, chair and clinical lead was on 16/8/17.

9. Scale of expected reviews

9.1. Figure one below shows the scale of expected reviews compared to the pilot teaching Trust involved in the RCP training.

Figure One

PILOT TEACHING TRUST

Higher Investigations

Structured Judgement reviews

Total Deaths

100

300

3000

18 complaints were received regarding deaths.

In FY 16/17 12 deaths in patients with learning difficulties occurred, all were reviewed at MRG and reported to the Oxfordshire Vulnerable Adults Mortality Subgroup (VAM).

9.2.3. The psychological medicine lead is being consulted about a definition of severe mental illness to guide clinical teams.
9.3. The Trust had 56% level 2 review with review of 1573 deaths as described above in FY 2016/17. The attached policy is designed to ensure that patients for structured review are identified within approximately 2 weeks of death such that structured review will replace level 2 review rather than duplicate it.

9.4. Wide consultation has indicated that teams wish to continue the current arrangements for level 2 review of a significant proportion of cases.

9.5. Systems for quality assessing structured reviews are still in discussion.

10. **Engagement with families**

10.1. National guidance on how to best engage with families is awaited.

10.2. The bereavement team have well developed skills

10.3. Currently the methodology in which the families are briefed on the investigation process; given the terms of reference of the investigation and allowed to add to them; updated monthly on progress of investigations; and have the opportunity to meet at the close of the investigation is in trial. This relies heavily on inputs from the divisional Clinical Governance and Risk Practitioners (CGRPs).

10.4. The current bereavement written information for families will be reviewed to ensure it informs them about structured review in a proportionate way understanding that this is expected to occur of only 10% of deaths and that higher levels of investigation will only occur in 3% based on pilot site data.

10.5. The Board may wish to note that some Trusts are pursuing a Medical Examiner model in which 1-2 WTE (whole time equivalent) experienced consultants are paid to review the case notes of every death and telephone every family to see if they have concerns. OUH has not currently adopting this model and an NHS event attended by the Chair of the Quality Committee and Deputy Medical Director earlier in the year heard that report on pilot sites has been put back to 2019.

10.6. The plan will need to be reviewed after national guidance is available.

11. **Risks**

11.1. Insufficient consultant time to complete reviews

11.1.1. Practice cases have been used and suggest that it takes around 30-60 minutes to complete a structured review which is similar to current level 2 reviews. It is anticipated that there will be a learning curve.

11.1.2. Mitigations are the consultation that has been undertaken with divisions and the training program which includes a growing library of Oxford examples.

11.2. Insufficient capacity for higher level investigations.

11.2.1. At present 14 deaths per year have been SIRIs and the pilot site anticipates a need for 93.

11.2.2. Higher levels of review may mean review at MRG (as currently intended) with a subset becoming SIRIs via the forum.

11.2.3. This will need to be kept under review and may have resource implications.
12. Conclusion

12.1. In accordance with new national mortality guidance, the Trust has updated the mortality strategy and is required to publish an updated mortality review policy by September 2017.

12.2. This paper presents the background to the updates to the OUH mortality strategy and revisions to the Standardised Mortality Review Policy. A summary of the changes to the Standardised Mortality Review policy is provided.

12.3. The revised Standardised Mortality Review policy is provided in the Appendix One to this paper.

13. Recommendation

13.1. The Board is asked to receive and discuss the OUH mortality review strategy and revised Standardised Mortality Review with a view to approving it for use in the OUH.

Report compiled by:

Dr Clare Dollery, Deputy Medical Director
Sandhya Chundhur, Clinical Outcomes Manager
Updated: 24th August 2017