Standardised Mortality Review Policy

Category:	Policy
Summary:	• A standardised process to review inpatient deaths, identify deficiencies in care, systems and/or process. • A mechanism promoting the identification of improvement actions and the sharing of learning. • A system to establish and monitor the number of potentially avoidable inpatient deaths.
Equality Analysis undertaken:	June 2017
Valid From:	1st April 2018
Date of Next Review:	30th September 2020
Approval Date/ Via:	Clinical Governance Committee
Distribution:	OUH Intranet
Related Documents:	Incident Reporting & Investigation Policy Version 13.1 – April 2016
Author:	Mortality Review Group
Further Information:	Mortality Review Group
This Document replaces:	Standardised Mortality Review Policy V2.0 (September 2017), Mortality Review Policy V1.0 (January 2014), Clinical Governance Committee (CGC2014.18a)

Lead Director: Deputy Medical Director (delegated responsibility from the Medical Director)

Issue Date: 1st April 2018

Document History

Date of revision	Version number	Author	Reason for review or update
30th September 2017	V2.0	Mortality Review Group	Publication of new national mortality guidance
1st April 2018	V3.0	Mortality Review Group	Updated Appendix 4: Involvement of bereaved families and carers
14th June 2018	V3.1	Mortality Review Group	Updated Generic Level 2 template
9th November 2018	V4.0	Mortality Review Group	Updated Structured Review template. Weblinks added to references.
11th January 2019	V4.1	Mortality Review Group	Updated Lead Director role.

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Divisional Clinical Governance meetings	Deputy Medical Director and Head of Clinical Governance attended the Clinical Governance meetings in all 5 Clinical Divisions to present and discuss the requirements of the national mortality guidance.
Mortality Review Group (MRG)	Discussion at Group meetings and E-mail consultation.
Clinical Governance Committee	Discussion at Clinical Governance Committee July 2017 meeting and via monthly updates from MRG.
Designated doctor for child deaths	E-mail consultation
Chair of Women's Clinical Governance Committee	E-mail consultation
Trust Management Executive (TME)	Submitted for discussion at TME 10th August 2017 meeting.
Quality Committee	Proposals for changes to the mortality review process presented to Quality Committee following publication of the national guidance. Revised mortality review policy submitted to Quality Committee 9th August 2017 meeting.
Trust Board	Submitted to Trust Board 13th September 2017 meeting.

Contents

Document History	2
Consultation Schedule	2
Who should read this document	4
Key standards	4
Background	5
Aim	5
Key Updates	5
Policy Content	6
Mortality Review Process	6
SIRI process and mortality reviews	9
Review	9
References	9
Appendix 1: Responsibilities	11
Appendix 2: Definitions	13
Appendix 3: Training	15
Appendix 4: Involvement of bereaved families and carers	15
Appendix 5: Child deaths	18
Appendix 6: Maternal deaths	18
Appendix 7: Learning disabilities deaths	18
Appendix 8: Mental health	19
Appendix 9: Reporting	19
Appendix 10: Notification of death and Level 1 review form	20
Appendix 11: Generic Level 2 review template	21
Appendix 12: Structured review template	25
Appendix 13: Monitoring compliance	32
Appendix 14: Equity analysis	33

1. Who should read this document?

1.1. This policy should be read by all clinical staff across the Trust.

1.2. The principles in this policy apply to the review of all inpatient deaths including Emergency Department cases within the Trust.

2. Key Standards

Standard 1: All Trust inpatient deaths must be reviewed.

Standard 2: All Units must complete Level 1 reviews on all deaths.

Standard 3: Specified Clinical Units[1] *must complete Level 2 reviews on at least 25% of deaths. All other Units must complete Level 2 reviews on all deaths.*

Standard 4: Child deaths must have a Level 2 review completed by the responsible team or where applicable the review is completed in accordance with the Child Death Overview Panel process.

Standard 5: Structured Review instead of Level 2 reviews is mandated in the following cases:

- *Bereaved families and carers have raised a significant concern about the quality of care provision*
- *Staff have raised a significant concern about the quality of care provision*
- *Learning disabilities*
- *Severe mental illness. Severe mental illness is defined as schizophrenia; schizoaffective disorders; bipolar affective disorder; severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records; the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.*
- *Maternal deaths*
- *Serious Incident Requiring Investigation (SIRI) involving a patient death*
- *Mortality alerts from audits, Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator*
- *Inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths"*
- *A further sample of other deaths will be selected that do not fit the identified categories, to ensure that the Trust can take an overview of where learning and improvement is needed most overall.*

[1] 'Specified units' General Surgery, Vascular Surgery, Respiratory Medicine, Cardiology, Palliative Medicine, Acute General Medicine, Geratology, Nephrology, Medical and Clinical Oncology, Trauma, Neurosurgery, Gastroenterology and Haematology.

3. Background

3.1. In March 2017 the National Quality Board published guidance based on the recommendations from the CQC report. The guidance requires that:

3.1.1. mortality governance should be a key priority for Trust Boards

3.1.2. an existing executive director should be identified as the patient safety director and a non executive director should oversee progress

3.1.3. each Trust should develop and publish an updated mortality policy

3.1.4. mortality data must be collected from April 2017 on a quarterly basis and published from Quarter 3 2017-2018 onwards

3.1.5. the mortality data providers publish be summarised in Quality Accounts from June 2018 in accordance with changes to the Quality Accounts regulations

3.1.6. a mortality surveillance group should be in place including multiprofessional membership

3.1.7. reporting to the board in public and communications with frontline staff about the outcome of investigations to share learning occur regularly

3.1.8. there be three levels of scrutiny of deaths namely, death certification, case record review and investigation

3.1.9. case record review should be robust, Structured Judgement Review (methodology from the Royal College of Physicians) or other recognised approach

3.1.10. reviews be objective and undertaken by clinicians not involved in the care

3.1.11. that there be cross system reviews and investigations

3.1.12. the Trust have 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.

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

4. Aim

4.1. To ensure that all inpatient deaths are reviewed and that the potential to learn lessons in order to improve clinical care, systems and processes is maximised. The opportunity to identify ways to improve and understand services for patients goes beyond simply the immediate cause of death.

4.2. To provide 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. To work more closely with bereaved families and carers and 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.

4.3. To work towards the elimination of all avoidable deaths.

4.4. To ensure Trust level data on inpatient deaths is complete and accurate.

5. Key Updates

5.1. The mortality review process will include a programme of structured review based on the Royal College of Physicians methodology.

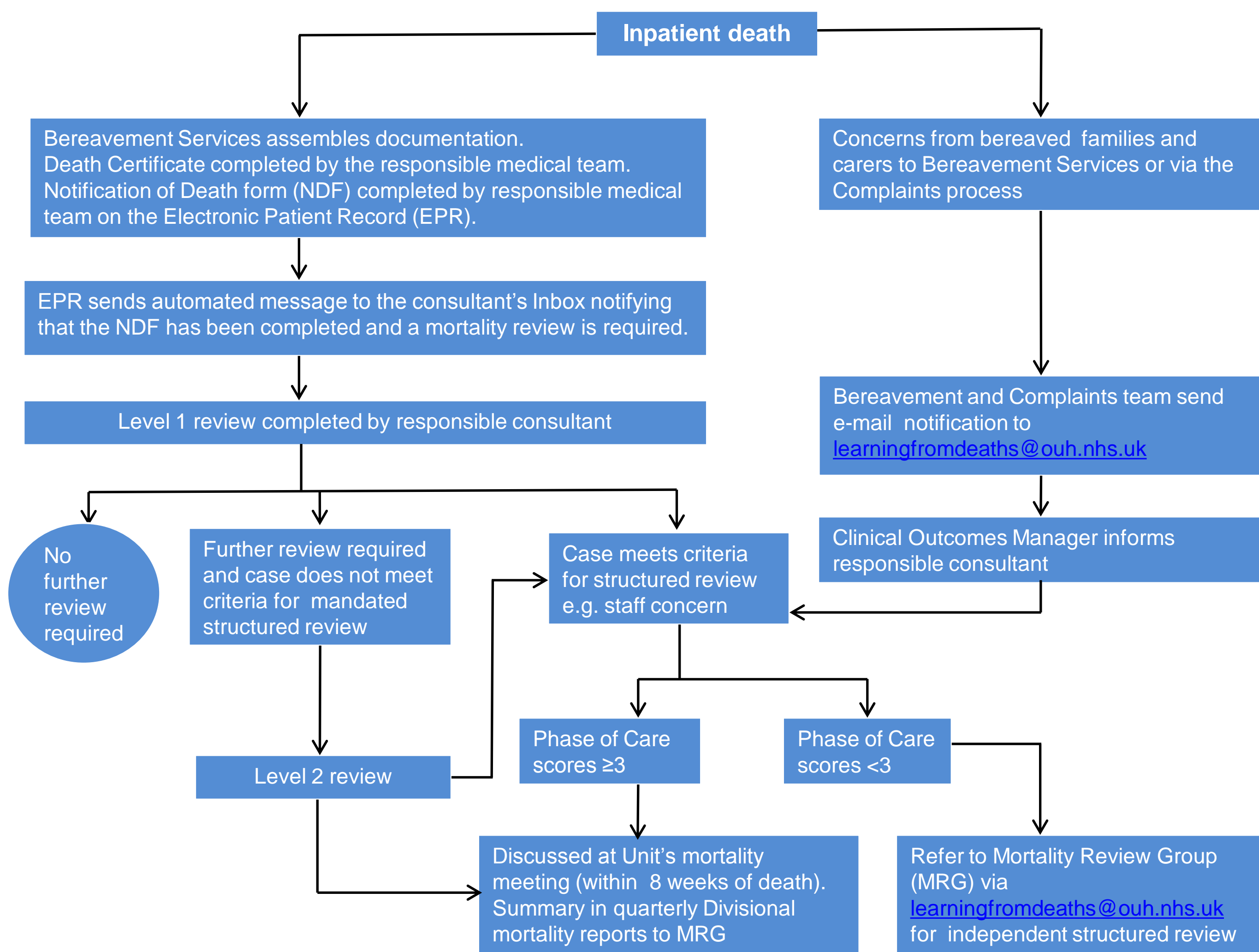
5.2. There will be executive and non executive oversight of the mortality review process.

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

5.4. The process for how structured review will be done and which cases OUH will select are detailed in the Content section of this policy.

6. Policy Content

6.1. Mortality Review Process



6.1.1. **All mortality reviews must be completed within 8 weeks of the death**

6.1.2. **Level 1 review**
A mortality review including a series of statements which the consultant responsible for the patient's care signs as either 'agree' or 'disagree'. If the

reviewer disagrees with any of the statements the case is referred for a Level 2 mortality review. If the case meets the mandated criteria the case is referred for a structured review.

6.1.3. **Mandated structured review criteria**

Structured judgement review methodology developed by the Royal College of Physicians 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. Structured review instead of a Level 2 review is mandated in the following cases:

- Bereaved families and carers have raised a significant concern about the quality of care provision
- Staff have raised a significant concern about the quality of care provision
- Learning disabilities
- Severe mental illness. Severe mental illness is defined as schizophrenia; schizoaffective disorders; bipolar affective disorder; severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records; the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.
- Maternal deaths
- Serious Incident Requiring Investigation (SIRI) involving a patient death
- Mortality alerts from audits, Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator
- Inquest and issue of a “Regulation 28 Report on Action to Prevent Future Deaths”
- A further sample of other deaths will be selected that do not fit the identified categories, to ensure that the Trust can take an overview of where learning and improvement is needed most overall.

6.1.4. **Level 2 review**

Multidisciplinary mortality review involving one or more consultants not directly involved in care. Where relevant, the input of a senior clinician from other relevant specialities should be invited. A Level 2 mortality review must occur:

- for child deaths or where applicable the review is completed in accordance with the Child Death Overview Panel process
- in any service not categorised as a Specified unit
- in a Specified unit if the consultant has not agreed with all statements on the Level 1 review
- in at least 25% of all deaths in a ‘specified unit’
  NB: if more than 75% are screened as not requiring review, then a random sample must be reviewed to ensure the 25% threshold is achieved

6.1.5. **Specified Units**

Clinical Service Units, where death is a frequent event have been categorised as ‘Specified Units’. The responsible consultant completes a Level 1 review and, where there is an absence of any concern in relation to care, a Level 2 review or structured review is not required. At least 25% of all deaths in a ‘Specified Unit’ require a Level 2 review. NB: if more than 75% are screened as not requiring review, then a random sample must be reviewed to ensure the 25% threshold is achieved. The Specified Units are:

- General Surgery
- Vascular Surgery
- Respiratory Medicine
- Cardiology
- Palliative Medicine
- Acute General Medicine
- Geratology
- Nephrology
- Medical and Clinical Oncology
- Trauma
- Neurosurgery
- Gastroenterology
- Haematology

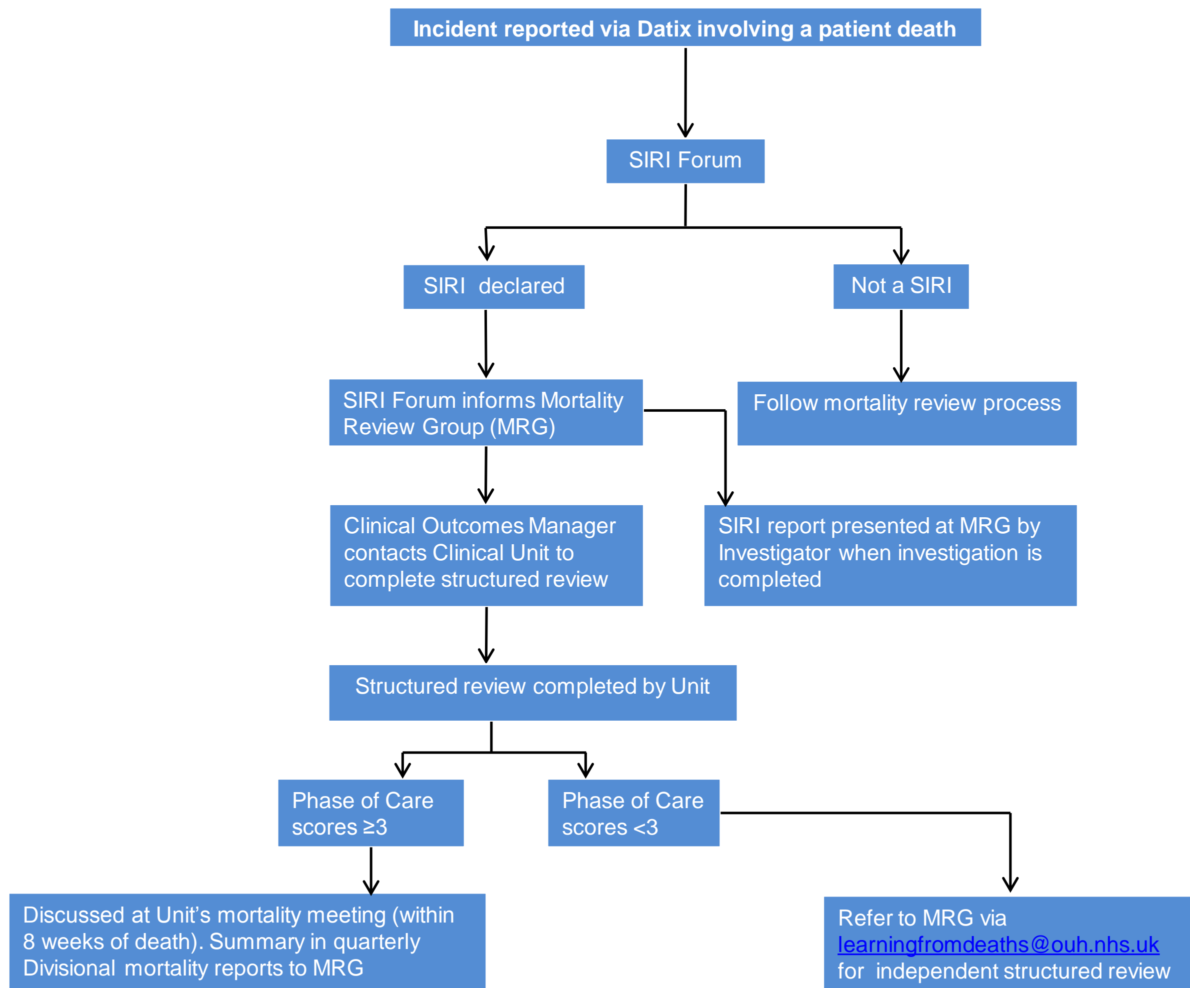
6.1.6. **Concerns about the quality of care provision**

In cases where clinical teams are aware of concerns at the time death or families and carers have raised concerns; the death must be immediately referred for a structured review. Where appropriate an incident must be logged, for the concerns raised, on the Datix electronic reporting system.

6.1.7. **Coroner’s referrals**

Consultant team refers case to the Coroner via the coroner’s e-referral process

6.2. SIRI (Serious Incident Requiring Investigation) Process and mortality reviews



7. Review

This policy will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents.*

8. References

Care Quality Commission, 2016. Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. Available at https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf (Accessed 6th November 2018)

National Quality Board, 2017. National Guidance on Learning from Deaths. Available at https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf (Accessed 6th November 2018)

Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N., 2009. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. British Medical Journal, 351:h3239. Available at https://www.bmj.com/content/bmj/351/bmj.h3239.full.pdf (Accessed 6th November 2018)

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Royal College of Physicians, 2016. Using the structured judgement review method A guide for reviewers. Available at https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf ((Accessed 6th November 2018)

Mazars LLP, 2015. 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. Available at https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf (Accessed 6th November 2018)

Appendix 1: Responsibilities

9. The **Chief Executive** has overall responsibility and final accountability for ensuring that the Trust has appropriate mortality review procedures in place; and that the Trust works to best practice as defined by relevant regulatory bodies.

10. The designated **Non-Executive Director** has oversight of progress with the national mortality guidance. The **Non-Executive Director** ensures that the Trust is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:
    10.1. the processes the Trust have in place are robust, focussed on learning and can withstand external scrutiny, by providing challenge and support;
    10.2. quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and support cultural change; and
    10.3. information published is a fair and accurate reflection of the Trust's achievements and challenges

11. The **Deputy Medical Director** is the Trust Management Executive (TME)-level leader acting as Patient Safety Director with accountability for the learning from deaths agenda. The Medical Director will be the board level lead who has delegated to the Deputy Medical Director. The **Deputy Medical Director** ensures that the Trust:
    11.1. has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;
    11.2. 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;
    11.3. 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;
    11.4. learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts.

12. The **Head of Clinical Governance** is accountable for establishing and maintaining a system that coordinates divisional data on mortality reviews to enable accurate Trust level data to be produced.

13. **Divisional Directors**, **Divisional Medical Directors**, **Divisional Nurses** and **Clinical Directors** are accountable for:
    13.1. ensuring the policy is implemented throughout the Divisions and Directorates;
    13.2. ensuring 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;

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

14. **Divisional Medical Directors** and/or other designated **Divisional Governance Leads** are accountable for reporting divisional mortality data to the Mortality Review Group or delegating this appropriately.

15. **Clinical Directors** are accountable for monitoring compliance with the policy and for ensuring structures are in place within clinical services to review deaths in accordance with this policy.

16. **Junior doctors** are accountable for completing the mortality notification form in the Bereavement Office when completing the death certificate.

17. **Hospital Consultants** are accountable for reviewing deaths in accordance with this policy and for ensuring the safe storage of mortality review forms to provide evidence that this process has been completed. In addition, hospital consultants are responsible for ensuring that any deficiencies in care, systems and/or processes identified through the review are shared and escalated through the divisional structures so as to facilitate wider organisational learning.

18. The **clinical team** are accountable for contributing to the multidisciplinary meetings where deaths are reviewed.

19. The **Bereavement Services Team** ensures the documentation for the deceased are completed. The Bereavement ServicesTeam ensures the death certificate is completed by the doctors, liaises with the Coroner's office, meet with the families (to give them the necessary paperwork, explain the registration process, provide an information pack, and arrange registration appointments and viewings during office hours). The Bereavement Team will provide notification of any concerns raised by families relating to the patient's death by e-mail to learningfromdeaths@ouh.nhs.uk.

20. The **Complaints Team** will provide notification of any complaints relating to the patient's death by e-mail to learningfromdeaths@ouh.nhs.uk.

21. The **Clinical Outcomes Manager** is responsible for:
    21.1. Disseminating relevant notices on the mortality review process to divisional teams.
    21.2. Notifying consultants of cases requiring structured review following concerns from families and carers raised to the Bereavement Services and Complaints teams.
    21.3. Reviewing benchmarked mortality data and initiating further investigations into relevant external alerts such as those received from the Dr Foster Unit at Imperial and the Care Quality Commission (CQC).
    21.4. Overseeing data collection systems for the mortality review process and reporting.
    21.5. Collating the mortality data centrally for quarterly publication.
    21.6. Management of the Mortality Review Group

22. The **Mortality Review Group (MRG)** is the surveillance group for OUHFT patient mortality. MRG acts as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.

23. The **Clinical Governance Committee** receives monthly reports from the Mortality Review Group and may commission specific reports as required.

24. The **Quality Committee** receives reports from the Clinical Governance Committee and may commission specific reports as required.

25. The **Trust Public Board** will receive quarterly reports on specified information on inpatient deaths.

Appendix 2: Definitions

26. **Notification of Death Form**: receipt of this form by the clinical directorate triggers a mortality review.

27. **Case record review**: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example, Structured Judgement Review methodology from the Royal College of Physicians.

28. **Level 1 review**: A mortality review including a series of statements which the consultant responsible for the patient's care signs as either 'agree' or 'disagree'. If the reviewer disagrees with any of the statements the case is referred for a full level 2 mortality review.

29. **Level 2 review**: Multidisciplinary mortality review involving one or more consultants not directly involved in care. Where relevant, the input of a senior clinician from other relevant specialities should be invited.
A Level 2 mortality review must occur:
    - for child deaths or where applicable the review is completed in accordance with the Child Death Overview Panel process
    - in any service not categorised as a Specified Unit
    - in a Specified Unit if the consultant has not agreed with all statements on the Level 1 review
    - in at least 25% of all deaths in a Specified Unit'
      NB: if more than 75% are screened as not requiring review, then a random sample must be reviewed to ensure the 25% threshold is achieved

30. **Specified Units**: Clinical Service Units, where death is a frequent event have been categorised as 'Specified Units'. The responsible consultant completes a Level 1 review and, where there is an absence of any concern in relation to care, a Level 2 review or structured review is not required. At least 25% of all deaths in a 'Specified Unit' require a Level 2 review. NB: if more than 75% are screened as not requiring review, then a random sample must be reviewed to ensure the 25% threshold is achieved. The 'Specified Units' are General Surgery, Vascular Surgery, Respiratory Medicine, Cardiology, Palliative Medicine, Acute General Medicine, Geratology, Nephrology, Medical and Clinical Oncology, Trauma, Neurosurgery, Gastroenterology and Haematology.

31. **Structured Review**: Structured judgement review methodology developed by the Royal College of Physicians 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. Structured Review instead of Level 2 reviews is mandated in the following cases:

- Bereaved families and carers have raised a significant concern about the quality of care provision
- Staff have raised a significant concern about the quality of care provision
- Learning disabilities
- Severe mental illness. Severe mental illness is defined as schizophrenia; schizoaffective disorders; bipolar affective disorder; severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records; the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.
- Maternal deaths
- Serious Incident Requiring Investigation (SIRI) involving a patient death
- Mortality alerts from audits, Summary Hospital-level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), Dr Foster Unit at Imperial, Care Quality Commission (CQC) or other external regulator
- Inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths"
- A further sample of other deaths will be selected that do not fit the identified categories, to ensure that the Trust can take an overview of where learning and improvement is needed most overall.

32. **Death due to a problem in care:** A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

33. **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation, in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

34. **Serious Incident Requiring Investigation (SIRI):** Serious Incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare. Every incident must be considered on a case by case basis.

35. **Avoidability:** The assessment of avoidability is framed by a six-point scale (6 = no evidence of avoidability; 1 = definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England. Making an overall summary judgement on whether death is avoidable (at least to some extent) is often a challenging process that goes beyond judging safety and quality by also taking into account comorbidities and estimated life expectancy.

Appendix 3: Training

36. Training in the Structured Judgement Review methodology will be provided to the designated Trust Mortality Leads for onward cascade training.

Appendix 4: Involvement of bereaved families and carers

37. The Trust should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below:

    37.1. bereaved families and carers should be treated as equal partners following a bereavement;

    37.2. bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;

    37.3. bereaved families and carers 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;

    37.4. bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;

    37.5. bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;

    37.6. bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;

    37.7. bereaved families and carers 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;

    37.8. bereaved families and carers who have experienced the investigation process should be supported to work in partnership with the Trust in delivering training for staff in supporting family and carer involvement where they want to.

38. **Opportunities for bereaved families and carers to raise concerns**

    Bereaved families and carers raise concerns either:

    38.1. directly with the **clinical team**

    38.2. by contacting the **Patient Advice and Liaison Service (PALS)**

    38.3. by making a formal **complaint**

    38.4. at their meeting with the **Bereavement Services team**

39. The **Bereavement Services team** lead on liaising with all families.

    39.1. The bereavement team will be responsible for reporting family's concerns to the learning from deaths e-mail address learningfromdeaths@ouh.nhs.uk

    39.2. The bereavement team advise families when they meet with them that the Trust reviews all patient deaths to find out if there is anything we can learn from the care provided. At this face to face meeting the families are asked if they have any

concerns in relation to the quality of care received by their relative or if there positive comments to be relayed to the teams.

39.3. The families are also provided with a leaflet, in the information pack, advising of the Trust's mortality review process and contact details should they have any concerns.

39.4. The OUH Bereavement booklet is currently being revised and the new version will include information on mortality reviews for bereaved families.

40. The **Complaints team** will be responsible for notifying all complaints associated with the death of a patient to the learning from deaths e-mail address learningfromdeaths@ouh.nhs.uk.

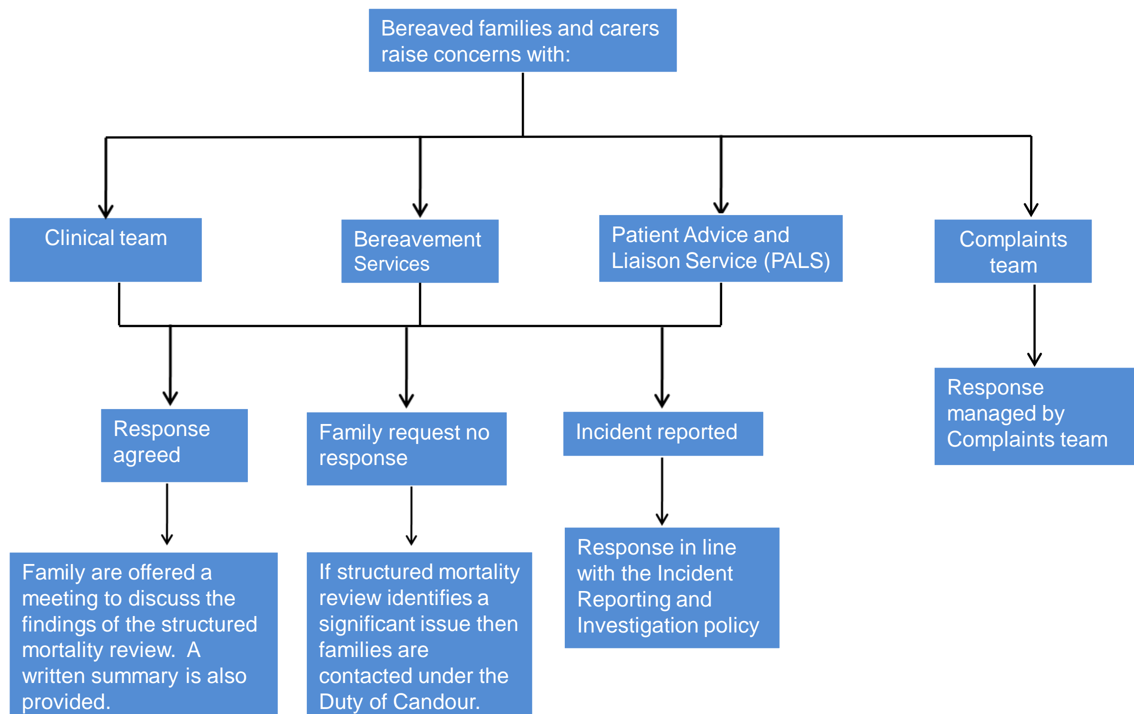
41. When a formal complaint is made the investigation and response is managed by the Complaints team in accordance with the OUH Complaints policy. The findings of the structured mortality review are considered when the response is collated for the families.

42. When concerns are raised informally and a response is requested; the family are offered a meeting with a representative of the clinical team to discuss the findings of the structured mortality review. A written summary of the findings of the review is also provided to the family.

43. There are cases when concerns are raised by families who advise the team that they do not want a response but would like their concerns to be considered as part of the mortality review. The families are informed that if there is a significant issue identified during the review the Trust would contact them in line with the Duty of Candour.

44. When there is an incident reported for the concern identified, this is investigated in accordance with the OUH Incident Reporting and Investigation policy. In line with the Trust's Duty of Candour; the families are informed of the incident, offered the opportunity for involvement in the investigation and offered a copy of the investigation report.

45. **Responding to concerns from bereaved families and carers**



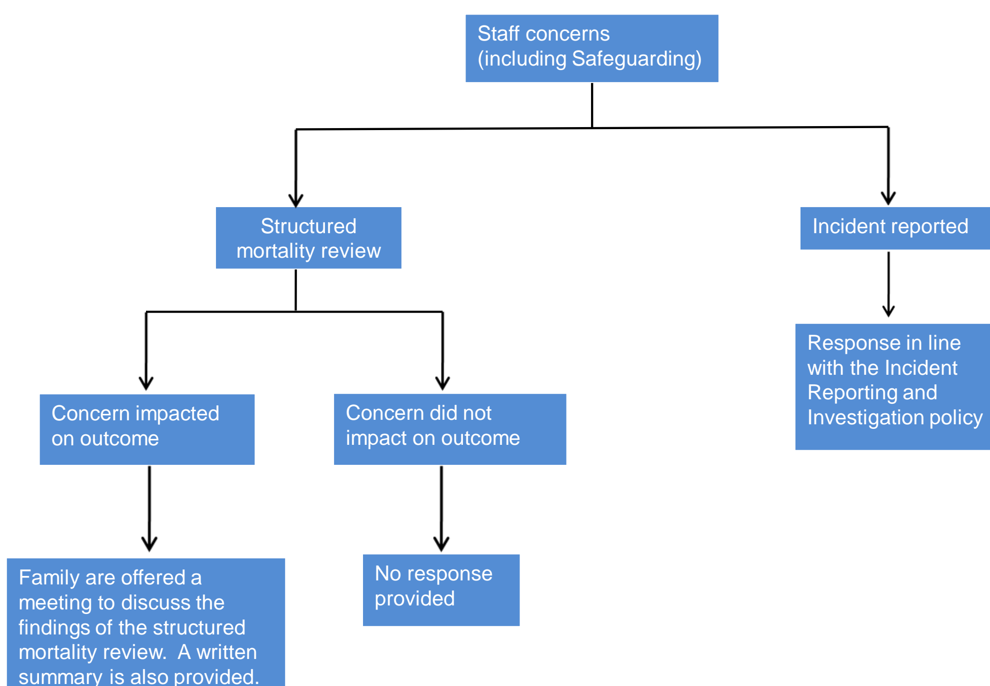
46. There are cases when staff raise a concern regarding the care provided to patients. This is a mandated criterion for a structured mortality review.
46.1. If the mortality review concludes that the concern identified impacted on the patient's outcome; then the families are contacted and offered a meeting with a representative of the clinical team to discuss the findings of the review. A written summary of the findings is provided to the family.

46.2. The bereaved families are not contacted if the review concludes that the staff concern did not impact on the patient's outcome.

46.3. If the staff concern becomes the subject of an incident investigation, this is investigated in accordance with the OUH Incident Reporting and Investigation policy. In line with the Trust's Duty of Candour; the families would be informed of the incident, offered the opportunity for involvement in the investigation and offered a copy of the investigation report.

47. Safeguarding concerns are logged as an incident on the Datix incident reporting system. The safeguarding concerns are investigated by the Safeguarding team in accordance with the Trust's Safeguarding policy.

48. **Communicating with bereaved families when concerns are raised by staff.**



Appendix 5: Child deaths

49. All stillbirths, neonatal and child deaths require a Level 2 mortality review.

50. Where applicable the review of a child death will be completed as part of the Child Death Overview Panel (CDOP) process. The findings from the CDOP review relevant for Trust wide learning must be included in the quarterly mortality reports.

51. The Perinatal Death Review Committee is a Standing Committee of the Women's Directorate Executive. The committee responsible for ensuring that a formal review takes place of all perinatal deaths within the Trust after 22 weeks gestation. The main objectives will be to determining the primary and secondary cause/s of death and to identify possible areas where care provision may be improved in the future, to reduce perinatal deaths and morbidity.

Appendix 6: Maternal deaths

52. All maternal deaths require structured review.

Appendix 7: Learning disabilities deaths

53. All deaths of patients with learning disabilities require structured review.

54. A system has been established for agencies in Oxfordshire, including OUHFT and OCCG, where patients with learning disabilities or their representatives can give consent for inclusion of their details on a data base which includes a flag on medical records within the Electronic Patient Record. The Trust Learning Disabilities Lead Nurse receives notification of the death of a patient with learning disabilities and

informs the Clinical Outcomes Manager who notifies the responsible clinical team that a structured review is required.

55. Following publication of the Mazar's report; the Trust is required to include specific criteria in the mortality reviews of patients with learning disabilities for delays in access, delays in access to treatment, dysphagia, hydration, nourishment, PEG insertion.

56. The mortality reviews for patients with learning disabilities must be presented at the Mortality Review Group within 8 weeks of the death occurring.

57. All deaths related to patients with learning disabilities must be reported to the OCCG and the Vulnerable Adults Mortality Subgroup (VAM) which is a subgroup of the Oxfordshire Adults Safeguarding Board. The findings of the mortality reviews must be provided to both OCCG and VAM following presentation at MRG.

Appendix 8: Mental Health

58. All deaths of patients with severe mental illness require structured review. Severe mental illness is defined as schizophrenia; schizoaffective disorders; bipolar affective disorder; severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records; the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.

Appendix 9: Reporting

59. From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting.
60. Publication of the data and learning points should be from quarter 3 2017/2017 onwards. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

61. Changes to the Quality Accounts regulations will require that the data published be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that the Trust has taken.

Appendix 10: Notification of death form and Level 1 review

NOTIFICATION OF DEATH FORM (PROMPT FOR LOCAL MORTALITY REVIEW)

A. TO BE COMPLETED BY THE DOCTOR PROVIDING MCCD (or referring on to the Coroner)

Patient Initials:		Certified Cause of Death (MCCD)
		1a
Medical Record Number (MRN):		1b
		1c
Date of admission:		2
Date of death:		

Discussion with Coroner's Office: 'Part A' completed ☐ No certificate provided (death referred to Coroner) ☐

Responsible Consultant (at death)			Clinical Unit / Service		
Name / Signature		**Date**		**Contact**	

*This form will be sent to a nominated member of staff within the relevant Clinical Directorate and copied to the responsible Consultant (where an OUH email is available) [**Action**: Bereavement Services Team]*

*If there is additional information that may be useful when undertaking a formal mortality review, please make a note of this overleaf [**Action**: Doctor filling MCCD or Bereavement Services Team*

B. TO BE COMPLETED BY RESPONSIBLE CONSULTANT WHERE LEVEL 1 REVIEW IS PERMITTED *

	AGREE	**DISAGREE**
I am satisfied with the cause of death as listed on the MCCD (above)		
To my knowledge, there were no significant errors of omission / commission from one week prior to admission to the time of death		
To my knowledge, no clinical incidents or adverse events occurred during the course of the admission (such as a fall, unexpected return to theatre, unexpected readmission, prescribing error…)		
To my knowledge, there were no issues in relation to negative patient experience raised by the patient or family, or known to me (such as a complaint…)		
I consider this death to have been unavoidable		

If you disagree with any of these statements, a formal mortality review must take place.

This death should be reviewed more fully	
I do **not** consider that this death requires further review	

Name / Signature		**Date**		**Contact**	

**** Level 1 review is permitted in the following services:** general surgery, vascular surgery, respiratory medicine, cardiology, palliative medicine, acute general medicine, geratology, nephrology, medical and clinical oncology, trauma, neurosurgery, gastroenterology and haematology*

Appendix 11: Generic Level 2 review template

Generic Level 2 Mortality Review Template

DEMOGRAPHICS			
Date of Review		Lead Reviewer	
Hospital (or NHS) Number		Responsible Consultant(s)	
Patient's Age		Age at Death	
Month of Admission		Date of Death	
Location of Death (ward)		Clinical Unit	

GENERAL INFORMATION	Yes / No	Brief comment
Working diagnosis on admission (ED or GP)		
Working diagnosis following initial clerking by inpatient team		
Working diagnosis following Consultant review		
Was this diagnosis supported by tests?		
Was the Coroner informed or consulted?		
Did a hospital interest post mortem take place?		
Did a Coroner's post mortem take place?		
Documented Cause of Death (MCCD) Ia Ib Ic II		
Charlson index comorbidities Acute Myocardial Infarction ☐ Stroke ☐ Connective Tissue Disorder ☐ Paraplegia ☐ Congestive Cardiac Failure ☐ Dementia ☐ Diabetic complications ☐ Diabetes ☐ Peripheral Vascular Disease ☐ Renal Disease ☐ Severe Liver Disease ☐ Liver Disease ☐ Peptic Ulcer Disease ☐ Cancer ☐ Pulmonary Disease ☐ HIV ☐ Metastatic Cancer ☐		
Other co-morbidities		

Was the patient identified as actively dying within 12 hours of admission?		If **yes**, you may proceed directly to 'TERMINAL PHASE' on page 3
ADMISSION	**Yes / No**	**Brief Comment**
Route of referral (ED, GP or Other)		
Admitted weekend or Bank Holiday?		
Time of arrival / admission (24h clock)		
Time from arrival to clinical attention (triage)		
Time from arrival to first recorded observations		
Time from arrival to 1st doctor review		
Grade of first doctor seen		
Time from arrival to 1st review by ST3+		
Time from arrival to 1st consultant review		
Was the patient admitted from an assessment area to ICU (including via operating theatre)?		
Was the patient prescribed intravenous antibiotics within 6 hours of admission?		
Time from prescription to administration of antibiotics?		
FIRST 24 HOURS		
Was there evidence of a clear management plan?		
Essential investigations obtained without delay?		
Were the initial management steps appropriate?		
Were there any omissions in initial management?		
Is an online VTE risk assessment documented?		
Was the VTE recommendation followed?		
Was a MUST Score undertaken (nutrition)?		
Was the patient weighed during the admission?		
Was a pressure sore assessment undertaken?		
Was a falls risk assessment undertaken?		
DURING THE INPATIENT STAY		
Was the patient admitted to the appropriate ward directly from an assessment area?		
How many Wards was the patient admitted to altogether (excluding assessment areas)?		
Did medical staff write in the notes every weekday?		
Was there any period when the patient was not reviewed by a consultant for >96 hours?		
GENERAL CARE		
Did a fall occur during the admission?		
Did a pressure sore occur post-admission?		
Did thrombosis (DVT/PE) occur during admission?		
Was hypothermia observed at any point?		
Was track & trigger undertaken appropriately?		
Was a track & trigger threshold met?		
If so, was appropriate action taken?		

Was there appropriate consultant supervision of junior staff?		
Could fluid balance have been better managed?		
Could nutrition have been better managed?		
ESCALATION OF CARE	**Yes / No**	**Brief Comment**
Was the patient admitted to ICU?		
If discharged, was a clear plan in place regards appropriate ceiling of care?		
If discharged, was a handover of care to an ST3+ doctor documented?		
If discharged, was the patient readmitted to ICU?		
INVESTIGATION RESULTS		
Severe electrolyte abnormality (Na <120 or >150; K<2.5 or >5.9)		
Raised troponin		
Acute renal failure		
Hypoglycaemia (<3mmol/l)		
Drop in haemoglobin of >2.9 g/dl over 24h		
INR >5		
HEALTHCARE ASSOCIATED INFECTION		
Any evidence of HCAI (including HAP, bacteraemia, Clostridium diarrhoea, SSI, wound infection, norovirus)?		
VIP (Visual Infusion Phlebitis) score >2?		
Was the VIP score documented appropriately?		
Was a urinary catheter inserted?		
Indication for insertion documented & appropriate?		
SURGERY OR PROCEDURE		
General anaesthetic?		
Conscious sedation?		
Unplanned return to theatre (or procedure room)?		
Change in planned procedure?		
Unplanned removal / injury / repair of organ?		
MEDICATION		
Prescribed medications not available?		
Vitamin K, Glucagon, 50% dextrose, Naloxone or Flumazenil prescribed >6 hours following admission?		
NEVER EVENTS		
During admission, did a 'Never Event' occur? http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124552		
TERMINAL PHASE		
Was a decision made to limit treatment?		
Was resuscitation status documented in the notes?		
Is there evidence of discussion with the patient and/ or carers?		

Was it documented that the patient was dying and management modified accordingly?		
Did the palliative care team see the patient?		
Were pre-emptive end of life medications used?		
Was organ and tissue donation discussed?		
LEARNING DISABILITIES	**Yes / No**	
Did the patient have a learning disability (please tick)? **No** indication of a learning disability (please stop here)		
Yes clear or possible indications from the case records of a learning disability (please provide assessments on the following specific criteria)		
Delays in access		
Delays in access to treatment		
Dysphagia		
Hydration		
Nourishment		
PEG insertion		
Best Interests Assessment		
CONCLUSION / OVERALL VIEW	**Yes / No**	**You MUST provide narrative to support any 'YES' answer**
Was there an undue delay in diagnosis?		
Was there an undue delay in delivering care?		
Was communication with patient / family poor?		
Was communication between professionals poor?		
Suboptimal care, but different management would have made NO DIFFERENCE to the outcome **(death unavoidable)**		
Suboptimal care - different management MIGHT have changed outcome **(avoidable death possible)**		
Suboptimal care – different management WOULD PROBABLY have changed outcome **(avoidable death probable)**		
Was there anything that could have been done differently?		
Was death explainable?		
Was death anticipated?		
Highlight notably good elements of care		
Score for standard of documentation (please score 1 to 7; 1 = very poor, 7 = excellent)		

OTHER COMMENTS

Appendix 12: Structured review template

Structured Review Template

DEMOGRAPHICS			
Date of Review		Lead Reviewer	
Hospital (or NHS) Number		Responsible Consultant(s)	
Patient’s Name		Age at Death	
Sex M/F		Postcode	
Date of Admission		Time of Admission	
Type of Admission (Emergency, Elective, Other - please specify)		Date of Death	
Specialty team at time of death		Location of Death (ward)	

GENERAL INFORMATION	Yes / No	Brief comment
Was the Coroner informed or consulted?		
Did a hospital interest post mortem take place?		
Did a Coroner’s post mortem take place?		
Documented Cause of Death (MCCD) Ia Ib Ic II		

Phase of care: Admission and initial management (approximately the first 24 hours)
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.
Phase of care: Ongoing care
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.

Phase of care: Care during a procedure
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.
Phase of care: Perioperative care
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.

Phase of care: End-of-life care / discharge care
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.
Phase of care: Overall assessment
Please record your assessment about the quality of care the patient received and whether it was in accordance with current good practice. Your assessment is as important as the score. If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during this phase. Very poor 1 2 3 4 5 Excellent Please circle only one score.

Please rate the quality of the patient record
Very poor 1 2 3 4 5 Excellent
Please circle only one score.

Learning Disabilities

Did the patient have a learning disability (please tick)?
No indication of a learning disability (please stop here)

Yes clear or possible indications from the case records of a learning disability
(please provide assessments on the following specific criteria)

1. Delays in access

2. Delays in access to treatment

3. Dysphagia

4. Hydration

5. Nourishment

6. PEG insertion

7. Best Interests Assessment

Assessment of problems in healthcare
In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.
Were there any problems with the care of the patient? (Please tick) **No** (please stop here) **Yes** (please continue below) If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case. **Problem types** **1. Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **No Yes** **Did the problem lead to harm? No Probably Yes** **2. Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **No Yes** **Did the problem lead to harm? No Probably Yes** **3. Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **No Yes** **Did the problem lead to harm? No Probably Yes** **4. Problem with infection control No Yes** **Did the problem lead to harm? No Probably Yes** **5. Problem related to operation / invasive procedure** *(other than infection control)* **No Yes** **Did the problem lead to harm? No Probably Yes** **6. Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **No Yes** **Did the problem lead to harm? No Probably Yes** **7. Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR)* **No Yes** **Did the problem lead to harm? No Probably Yes** **8. Problem of any other type not fitting the categories above No Yes** **Did the problem lead to harm? No Probably Yes**

Learning and actions
In this section, the reviewer is asked to list the learning points identified and any actions to address problems highlighted in the review.

Avoidability of death score
We are interested in your view on the avoidability of death in this case. Please choose from the following scale. **Score 1** Definitely avoidable **Score 2** Strong evidence of avoidability **Score 3** Probably avoidable (more than 50:50) **Score 4** Possibly avoidable but not very likely (less than 50:50) **Score 5** Slight evidence of avoidability **Score 6** Definitely not avoidable
Please explain your reasons for your assessment of the level of avoidability of death in this case, including anything particular that you have identified.

____
Signature of Lead Reviewer

Length of time for review: ______minutes

____
Date

Appendix 13: Monitoring Compliance

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
Number of reviews versus deaths in each Division, triangulated with ORBIT data.	Review of quarterly divisional mortality reports and ORBIT extracts	Clinical Outcomes Manager	All deaths reviewed within 8 weeks of occurrence	Mortality Review Group
Appropriate level of review	Random sample of 25 cases reviewed to determine whether the level of review (Level 1, Level 2 or Structured Review) was appropriate	Mortality Review Group	25 cases reviewed	Clinical Governance Committee
Mandated Structured Reviews	Review report from Complaints team of all complaints related to patient deaths and learning disabilities database and confirm that Structured Reviews were completed in each case	Clinical Outcomes Manager	Structured Reviews were completed in each case	Mortality Review Group
Quality of Structured Reviews	Random sample of 10 cases which had Structured Reviews.	Mortality Leads	All Structured Reviews were completed in accordance with the methodology.	Mortality Review Group

Appendix 14: Equality Analysis

Have you considered how the Policy will affect people:	Yes	No	How have these groups been included in the development of the Policy?	How will the Policy affect them?
Who have a physical or sensory impairment? Have you consulted with them?	✓			There is no potential to discriminate on these grounds.
With a disability?	✓			There is no potential to discriminate on these grounds.
Of different gender?	✓			There is no potential to discriminate on these grounds.
Of different ages?	✓			There is no potential to discriminate on these grounds.
With different racial heritages?	✓			There is no potential to discriminate on these grounds.
With different sexual orientations?	✓			There is no potential to discriminate on these grounds.
Who are pregnant or recently had a baby?	✓			There is no potential to discriminate on these grounds.
With different religions or beliefs?	✓			There is no potential to discriminate on these grounds.
Who are going through gender re-assignment or have transitioned?	✓			There is no potential to discriminate on these grounds.
Of different marital/partnership status?	✓			There is no potential to discriminate on these grounds.
Who are carers?	✓			There is no potential to discriminate on these grounds.
Any other group who may be affected by this policy	✓			There is no potential to discriminate on these grounds.

Summary of Analysis

Does the analysis show evidence of:	Yes	No	Please explain your answer
The potential to discriminate?		✓	There is no potential to discriminate on these grounds.
The advancement of equality of opportunity?	✓		There is no potential to discriminate on these grounds.
The promotion of good relations between groups?	✓		There is no potential to discriminate on these grounds.