Taunton and Somerset NHS Foundation Trust	Trust Policy
Title: Mortality review	
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Document Lead: Stuart Walker – Medical Director	
Accepted by: Mortality Steering Group (Chair) **Ratified by:** Policy Review Group	**Active date**: 25th Sept 2017
Approval date: 25th Sept 2017	**Review date**: 25th Sept 2020
Applies to: All staff involved in reviewing and learning from deaths	**Exclusions:** None
Purpose: To provide guidance in the trust process for the review, monitoring and learning from inpatient deaths	
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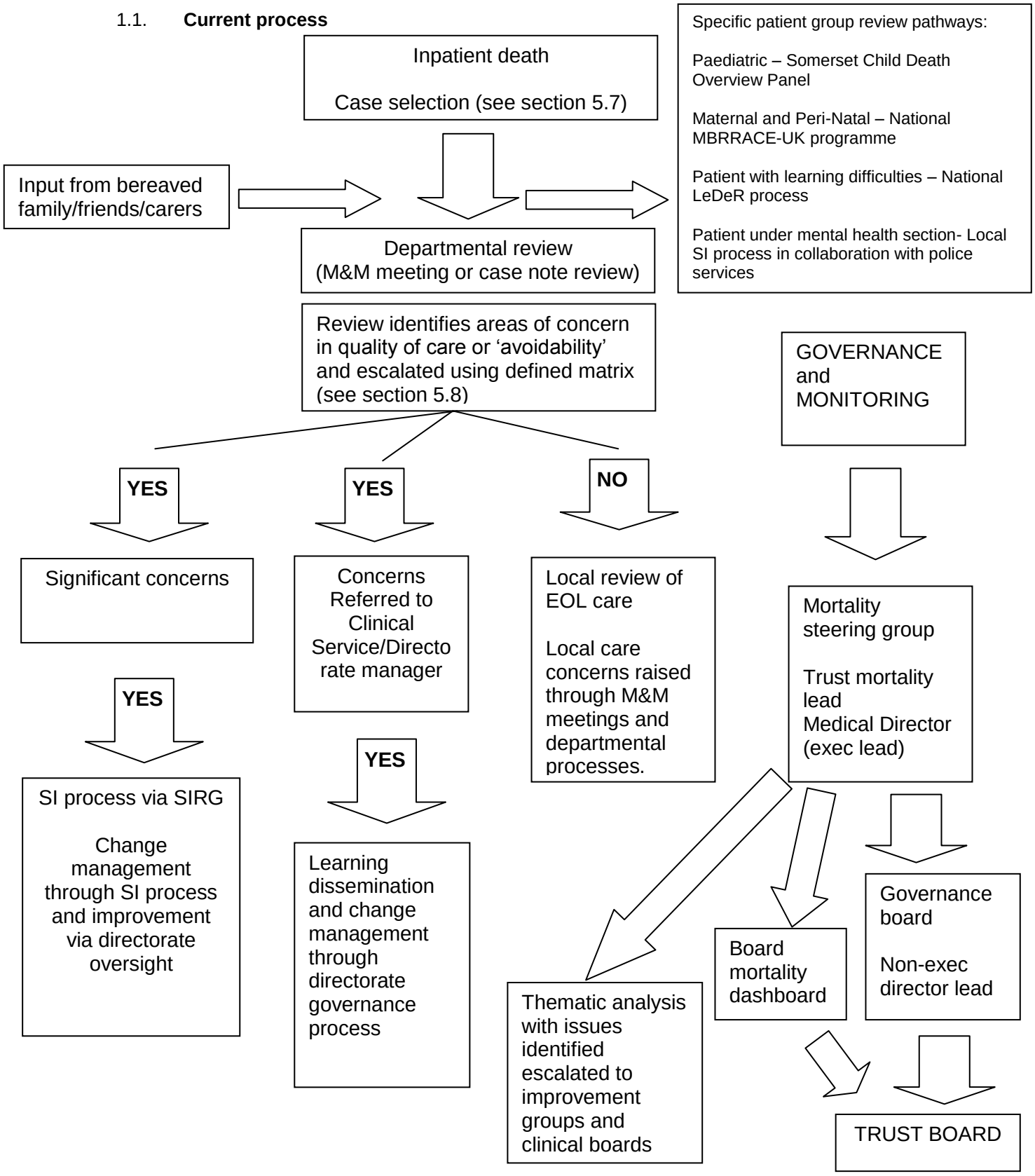
Key Points:

- **Mortality reviews are important, to ensure continual learning within MPH, and thus to improve the quality of the care we deliver.**
- **The input from family of the deceased is vital at all stages of the review.**
- **The Mortality Steering Group (MSG) is responsible for the governance and monitoring of this process and reports to the Board.**
- **The MSG report to the Board fulfils a number of new regulatory requirements in relation to learning from deaths, which include: Collecting quarterly information in relation to mortality reviews – which is then reviewed at a Public Trust Board, and publishing an annual review of our mortality data in our Quality Accounts**

1. Mortality review process

1.1. Current process



2. Introduction

2.1. The review of mortality information is important to help improve care and ensure patient safety within Musgrove Park Hospital.

2.2. The early input from bereaved families/friends of patients who have died within MPH is paramount to this process and is encouraged throughout the review process.

2.3. Mortality data from both qualitative review (at directorate/departmental level) as well as higher level quantitative data needs to be used to aid 'learning from mortality' within the Trust as well as provide oversight and governance around inpatient deaths.

2.4. Mortality data has been part of the standard board report for some time. This will be organised to comply with national standards (NQB - National Guidance on Learning from Deaths).

2.5. The Mortality Steering Group (MSG) (chaired by the Trust Mortality Lead and Medical Director) terms of reference are included as appendix A (as an illustration of function and duties/responsibilities) and should be taken in context with this policy.

2.6. Mortality review and specifically 'learning from deaths' cannot be taken in isolation and is intricately linked to the trust review of serious incidents (via SIRG) and departmental/directorate governance.

3. Definitions

The following definitions (and abbreviation) will be used throughout this policy document:

3.1. Standard mortality rates (SMR): SMR is the ratio of the observed or actual hospital mortality and the predicted hospital mortality for a specific time period. There are two types of SMR metrics; the HSMR (Hospital Standardised Mortality Rate) and the SHMI (Summary Hospital Level Mortality Indicator).

3.2. Mortality Case Review: Case note review (by Consultant or Senior trainee ST3+). Methodologies include the Royal College of Physician Structured Judgement Review and PRISM method. Thematic review of notes using standardised proforma.

3.3. Mortality and Morbidity meetings (M&M): Formal structured meetings comprising of a number of consultants, medical trainees and (in some cases) non-medical staff. Cases are discussed in a non-judgmental forum with aim for early dissemination of learning.

3.4. Learning Disabilities Mortality Review (LeDeR): National review process (managed regionally) for review of deaths of patients with learning disabilities.

3.5. Mortality Steering Group (MSG): Formal oversight committee tasked by the trust board to oversee mortality review processes (see Appendix A)

3.6. Mortality Case Investigation: Formalised investigation as per Serious Investigation (SI) policy brought about following the Mortality Case Review.

4. Duties/Responsibilities

4.1. The responsibility of the mortality review process lies with the Trust Board, delegated to the MSG (via the Governance Committee).

4.2. The Executive Director responsible for mortality review is the Medical Director.

4.3. The Non-Executive Director responsible for mortality review process is the Non-Executive Director responsible for governance.

4.4. The 'flow chart' for the mortality review responsibility is shown below:

4.5. The responsibilities of the Mortality Lead and the MSG are within the terms of reference, in appendix A.

5. Processes / arrangements and practice guidance (under appropriate headings / sub-headings as required)

5.1. The process described below (5.6 To 5.8) refers to the identification, review and dissemination of learning from adult inpatient deaths. As with national guidance, the following exclusions (and provisions for specific review) are stated below:

5.2. Paediatrics – Paediatric mortality review and dissemination of learning is organised through the Somerset Local Safeguarding Children's Board - Child Death Overview Panel. This is delivered in line with the NHS England Child Mortality Review Programme.

a. The Trust is represented by a Lead Consultant Paediatrician and the multi-agency review is laid out in the terms of reference of the Children's Board.
b. The output from the Board is fed back, via the Lead Paediatrician, to the MSG and within the Paediatric Department.
c. For paediatric deaths within MPH, the Lead Consultant is responsible for arranging early debriefing and incident analysis to take forward any learning actions (and activate local SI processes as appropriate). This is fed back to the Paediatric Improvement Group meetings to ensure dissemination and implementation of change/learning.

d. Early involvement of the parents/family is paramount and fundamental to the internal review process.
e. The Paediatric Department, wider directorate governance committee and the MSG provide review and governance of this internal process.

5.3. Maternal and peri-natal deaths – Mortality review and dissemination of learning is run through the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK) Programme.

a. The maternal and peri-natal death governance (within the directorate) is co-ordinated by the Governance Support Midwife.
b. External review: External review (through MBRRACE-UK) produces an annual report which is presented through both the MSG and the Women and Children's Directorate governance structure.
c. Internal review. Internal review of both maternal and peri-natal deaths is run concurrently with the national programme.
d. Maternal deaths - Internally, all maternal deaths are investigated through the Trust SI framework and the outcomes are presented through the directorate governance system. Any post-discharge maternal death (up to 1 year) is retrospectively reviewed by the Governance Support Midwife and, as appropriate, fed into directorate governance systems.
e. Peri-natal deaths - Internally, all peri-natal deaths undergo a Root Cause Analysis (RCA) review. This is either through the Trust SI framework or as a local RCA investigation. All reviews are then presented through the directorate governance system.

5.4. Patients with learning difficulties – All deaths of people with learning difficulties (aged 4 or over) are subject to review using LeDeR methodology.

a. The Trust is actively involved in the regional LeDeR programme through NHS England and the University of Bristol. This is hosted by Somerset CCG and the Trust is represented by the Learning Disabilities Liaison Team.
b. Annual reports from the regional LeDeR programme are presented through MSG and the Trust's Learning Disabilities Group.

5.5. Patients under mental health section – Any deaths of patients under a mental health section are referred to the Somerset Coroner for inquest as per national policy.

a. They are also referred to the Care Quality Commission (CQC) as per national guidance.

b. Internally, they are investigated via the SI processes. Information and learning from this process is disseminated via the SIRG and as per SI policy.

5.6. Bereaved Families and Carers (professional and non-professional)

a. The Trust will engage meaningfully and compassionately with bereaved families and carers throughout the process; as directed by them and their needs.

b. These commitments are in line with our policy 'Being open and the duty of candour'.

c. The Trust recognises bereavement care is important and is committed to:

• Actively engaging with bereaved families and carers and treating them as equal partners.

• Treating bereaved families and carers with respect for their confidentiality, values, culture and beliefs.

• Providing appropriate support to bereaved families and carers in conjunction with other services. For example, community and mental health services to ensure best possible care of bereavement.

• Being open regarding their rights to raise concerns about the quality of care provided (including the quality of care around end of life care provision).

• Working within the Trust and with other care partners to co-ordinate support to encourage involvement in all appropriate stages of an investigation.

• Acknowledging bereavement reactions may be related to wholly or as part of the episode of care rather than the death itself

d. The Trust will support staff in line with its policy of staff care and wellbeing. This will appreciate the challenges personally to the employee and within teams an investigation can create and seek to maintain their resilience.

5.7. **Identification and selection of inpatient deaths for review:**

a. The review of inpatient deaths has, in many departments, been standard practice for many years. For this reason, the deaths (under each department) are identified by the Departmental Mortality Lead, at a local level.

b. The identification of patients who have died within Musgrove Park is done via the PAS system (IMS MAXIMS). This is supplemented by local databases and admission/discharge data from some isolated clinical areas (e.g., Intensive Care Unit) and data sources within bereavement.

c. Deaths that have been referred to the Coroner are additionally identified to the Legal Services Department by the Coroner's Officer.

d. Certification of death and standard procedures around inpatient deaths are performed via the Bereavement Office as per Trust policy/practice. It is good practice that all deaths, prior to certification, are discussed with the named responsible consultant or designated clinician (either another consultant or registrar within the same clinical team). The completions of death certification and cremation administration are completed by a medical practitioner involved within the patient's final inpatient episode as per national guidance. All deaths are discussed with the designated Consultant Histopathologist to discuss wording for the certification and to help clarify issues around certification.
e. Primary Care Practitioners (patient's designated General Practitioner) are informed of a patient's death within Musgrove Park via a standardised 'Notification of death' via the EPRO programme. This is distributed via email within 24 hours of the inpatient death.
f. Primary care practitioners/healthcare professionals from Somerset Partnership or General Practitioners can, at any point, raise concerns regarding deaths in the community following a recent inpatient stay. This can be raised through the Governance Support Unit (GSU), PALS or the Trust Mortality Lead. The individual cases will then be subject to the same review (and potential investigation) process as inpatient deaths. Feedback would then be provided to both the healthcare professional and the family/carers (in line with Duty of Candour) following review.
g. Input from family at this early stage is paramount and input from bereaved families is fed to the individual Consultants/Departmental Mortality Leads/Trust Mortality Lead from the Bereavement Office Team or PALS.
h. If a formal complaint is lodged or a 'Serious Incident' investigation is commenced, (see 5.3) the Trust will fully disclose all information to the bereaved family and/or carers as per duty of candour arrangements, laid out in the SI policy and 'Being open and Duty of Candour' policy.
i. The Trust aims to review over 50% of mortality cases at departmental level, via the methodologies described above. This is performance reviewed at the MSG and feedback is given to departments on numbers of cases reviewed. Cases for automatic inclusion include:
    - Patients admitted electively where patient would not be expected to die
    - Patients where the death has been referred to the coroner
    - Patients admitted with a learning disability
    - Cases in which family/friends have raised a significant clinical concern
    - Cases in which staff have raised a significant clinical concern
    - Patients under a Deprivation of Liberty Order at the time of death

Further random samples of deaths are then reviewed (to ensure an overall review rate of over 50%). In these cases, especially where the death is considered to be unavoidable (and in many cases expected), it is paramount that end of life processes and quality of care are reviewed.

5.8. **Review of inpatient deaths**

a. The Trust recognises that a variety of mortality review methodologies were in place prior to the formation of the MSG and formalisation of the Trust mortality processes. The two recognised methodologies for mortality review within MPH are: Mortality meetings (departmental) and structured case note reviews. It is not uncommon for a mix of methodologies with cases that have been reviewed by a single clinician (structured case notes review) then being presented and discussed in a departmental mortality meeting.

b. All reviewed cases within MPH are completed on the designated MPH Mortality Review Form (Appendix B) and these are collated by the in the Governance Support Unit. The data from these forms is used with the MSG and Board reporting structures.

c. Mortality meetings – The format of these meetings is developed at a departmental level. They are strongly encouraged to be multi-disciplinary and include doctors in training. The meetings are a formal section of consultant job plans (SPA) and registers are taken. They form part of consultant yearly appraisal. The mortality cases are reviewed by a consultant/registrar and are presented to the group for discussion. The meetings are chaired by a consultant (either rotational between departmental consultants, the departmental Mortality Lead or Clinical Service Lead).

d. Mortality meetings are not specified within the National Quality Board (2017) guidance (although they are within the Royal College of Physicians Structured Judgment Review Guide and the Royal College of Surgeons of England guide to Mortality and Morbidity meetings). However, the Trust feels strongly that they are a valuable resource for reviewing mortality cases and, importantly, as one method of disseminating learning and change following mortality review. There is strong literature validity in using mortality meeting to discuss and learn from deaths within acute trusts.

e. Structured case note reviews- These are undertaken by registrar/consultants within departments and cases are allocated by the Mortality Leads.

f. Combination of methodologies- Some departments review cases using structured case notes reviews and then bring selected cases to departmental mortality meetings.

g. Due to the complexity of clinical care, many clinical cases are discussed in more than one department. This is appropriate and encouraged in clinical complex cases or cases in which the intervention of multiple specialities during the final inpatient stay was needed. Cases can be referred between Mortality Leads at department level or re-directed by the Trust Mortality Lead/Governance Support Unit as appropriate.

h. Following review, the Trust Mortality Review Form is completed. The form allows the collection of demographic data, thematic analysis (to areas of concern) and classification of the cases along two scales. The Trust requires the classification of both the avoidability and the quality of care of the final clinical episode.

i. Supporting narrative content should be included where relevant to provide a clear basis for judgement reached about quality of care (and avoidability). Clear, concise judgement statements are to be used which make the key factors in determining 'good care' as well as any quality issues explicit. This is in line with the principles of Structure Judgement Review Methodology as the method or review advocated nationally.

j. Avoidability: 'Avoidability' is difficult to define and classify when reviewing mortality cases. The use of multi-consultant decision making in classification of 'avoidability' is encouraged. The scale used is a 1-4 scale: 1. Unavoidable, 2. Possibly avoidable but not very likely, less than 50:50, 3. Probably avoidable, more than 50:50 and 4. Strong evidence for avoidability/definitely avoidable. This scale is used as both a MSG and Trust Board reportable measure but also as a method of identifying the need for further investigation.

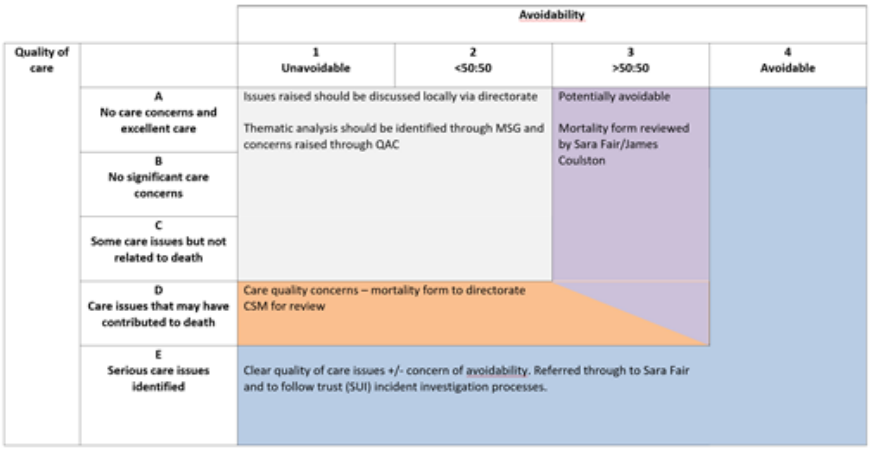
k. Quality of care: As with avoidability this is a subjective review about the quality of care provide by MPH and its staff in the patient's final clinical episode. Factors such as 'the use of 'treatment escalation documentation (TEP)', documented discussions with patient and family members and feedback from the family are used in formulating this decision. The quality of care score is an A-E scale and used in a similar fashion to the avoidability score. The scale used is: A. No significant care issues identified and care considered to be excellent despite the outcome, B. No significant care issues identified, C. Some care issues identified but not related to death, D. Care issues identified which may have contributed to death and E. Serious issues identified (failure to follow procedures/ unacceptable standards of care).

l. Access to death certification documentation is via the Bereavement Officer. The Coroner has granted permission for a shared drive to be set up within MPH internal server. Deposited within this are the post mortem (PM) reports from

PM's performed at MPH. These are available for review by departmental Mortality Leads to aid discussions/learning at mortality meetings.

m. A Consultant Histopathologist (involved in PM's within the trust) is a standard member of the MSG.

5.9. **Need for further investigation and dissemination of learning from inpatient deaths**



a. Learning is disseminated at multiple stages within the mortality review process. Due to the substantial number of reviews and the high proportion of unavoidable deaths it is paramount that significant failures in quality of care should be primarily identified and taken forward to allow process analysis and process change.

b. The use of mortality meetings at departmental level encourages learning through discussion of clinical cases. These are part of consultant core activity and are mandated for junior medical staff. The use of multi-disciplinary mortality meetings is strongly encouraged.

c. Issues arising from these mortality meetings that can be addressed at a local level are taken forward by the mortality leads and departmental clinical service leads/managers.

d. To help structure dissemination of learning in cases in which there has been a significant quality of care concern or there is concern that the death may have been avoidable the following grid has been implemented.

e. In cases where serious care issues are identified and the death is thought be have been avoidable or potentially avoidable then the case is referred through to the trust SI process (via the Incident and learning manager) and overseen by the SIRG. These cases will be investigated as serious incidents and reported/disseminated as appropriate. In these cases the family will be contacted as per duty of candour arrangements.

f. In cases where care issues are identified that may have contributed to death but the death was thought to be unavoidable (or probably unavoidable <50:50) the Mortality Review Form is forwarded to the Clinical Service Manager/Directorate Manager for further investigation. Action planning (change management), learning and dissemination of learning are achieved through integration with the directorate governance processes.

g. In cases where the death was potentially avoidable (>50:50) the mortality case form is reviewed by the Incident and Learning Manager and Trust Mortality Lead. Further case note review may be needed and the case then referred either to the SI process (5.8e) or back into directorate governance (5.8f), as appropriate.

h. Cases in which trust wide learning or process change needs to be enacted can be referred directly through to the improvement directorate and the appropriate improvement board.

i. The use of the mortality review process to investigate trust wide/recurrent concerns as well as thematic analysis of areas of concern in mortality cases is addressed and directed by MSG (see section 5.9)

j. Mortality review outcomes from within the Trust are disseminated to the General Practitioner electronically (via trust EPRO system) as previously described. Further integration with SOMPAR (Somerset Partnership Trust) and Somerset CCG (Clinical Commissioning Group) (with respect to mortality review) is expected.

5.10. **Review of mortality data at a trust level (MSG)**

a. The assimilation and review of mortality data is a function of the Mortality Steering Group (MSG). The TOR are in appendix A and state the mortality review requirement of the committee. This committee will provide a trust board report/mortality dashboard (for publication on a quarterly basis) and reports directly to the Trust Governance Committee.

b. Specific, to this policy, the MSG will review:

The number of mortality reviews performed at Trust and departmental level.

The output from these reviews and numbers of clinical care concerns and ‘avoidable’ deaths.

Thematic review of care concerns during final MPH admission.

Mortality data (above) by weekend/weekday admission.

Review of inpatient deaths review process.

c. Review of ‘national’ quantitative mortality markers (eg. SHMI, HSMR, Crude mortality rate)

d. Review of diagnostic groups of concern. Either raised through national data (i.e. CQC mortality alerts/Dr Foster mortality alerts/national registers of speciality data (e.g. National Hip Fracture Database or National Vascular Register), diagnosis groups with significantly higher than expected standardised mortality ratios, diagnosis groups with a cumulative summary (CUSUM) value of 3.5/HEDlines.

6. Performance Monitoring

6.1. Performance monitoring for this policy and the mortality review process will be through the MSG. This is laid out in section 5 of the MSG terms of reference (Appendix A)**.**

7. Review

This document will be maintained by the author to reflect the most up to date national guidance as applicable, and/or the current research literature (for clinical guidance documents). For information, Appendix C sets out some process developments which, once implemented, will be reflected in further updates.

8. References

- National Guidance on Learning from Deaths, National Quality Board, March 2017
- Learning, candour and accountability, Care Quality Commission, December 2016
- Horgan et al. Preventable deaths due to problems in care: a retrospective case record review study. BMJ Quality and Safety, 2012.
- Royal College of Surgeons of England: Morbidity and Mortality Meetings A Guide To Good Practice (Supports good surgical practice: domain 2- Safety and Quality), 2015.
- Using the structured judgment review method- A guide for reviewers; Royal College of Physicians (National Mortality Case Record Review Programme), 2016.

9. Equality Impact Assessment (EIA) statement

As the arrangements set out in the policy provide no potential based for equality concerns, full assessment has not been considered necessary.

APPENDIX A

MORTALITY SURVEILLANCE GROUP

TERMS OF REFERENCE

1.0 Strategic Statement

The Mortality Surveillance Group (MSG) is formed to support the Trust in delivering its obligations to monitor patient outcomes and ensure clinically effective care. The Group will act 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.

The group operates as part of the Trust's wider integrated governance arrangements, with strategic links to both quality improvement and quality assurance objectives.

2.0 Constitution

The MSG is constituted on the authority of the Medical Director and with reference to the guidance on Mortality Governance issued to Trusts by NHS England. It is established as both a Specialist Committee and a Steering Group to take the Lead in the governance of mortality and morbidity processes within the Trust.

The Group retains the core functions of the pre-existing Data Outlier Review meeting, constituted in in line with the recommendations of the National Advisory Group on the Safety of Patients in England, 2013 - the 'Berwick Report'.

3.0 Authority

The MSG is authorised by the Medical Director to investigate any activity within its Terms of Reference. It is authorised to seek any information from any employee during this process.

The Chair of the meeting may escalate significant issues linked to its activity and aims to relevant senior management, including to Trust Board. This may include issues linked to individual staff responsible for contributing to M&M review within specific services or for responding to data outliers, especially where there are issues with co-operation to achieve the group's aims.

4.0 Objectives

The main objectives will be to:

- Develop and oversee the Trust's strategy for reduction of avoidable morbidity and mortality to a minimum
- Develop and oversee the systems relied upon to review deaths within the hospital, including specialty M&M meetings
- Ensure an effective response to signals of quality concerns within the relevant sources of intelligence about outcomes
- Provide assurance to the Trust Board on mortality performance and of comprehensive arrangements for mortality surveillance and learning
- Ensure that genuine improvements are made to address quality issues detected via M&M and data outlier review activities through monitoring and sign-off of relevant actions.

5.0 Duties and Responsibilities

The MSG will undertake the strategic and procedural functions outlined within the MSG model Terms of Reference and integrate these with the existing arrangements for review of key benchmarked data sources.

1) Review the benchmarked standardised mortality rates of the Trust

2) Review of specialty-based M&M activity with a view to identify potential areas for investigation and gain assurance on the operation of effective review processes at service level. To be achieved via structured reporting to address specialty level M&M resources, structures, process and outputs.

3) Consider the mortality data in conjunction with other qualitative clinical data and identify areas for investigation. ie. to consider the outputs of local case note review M&M activity alongside statistical (SMR) data and other contextual information about the service and the data.

4) Investigate alerts and other outlier notifications received from the CQC or identified systems (e.g. HED, National databases, national audits).

5) Steer development of data collection systems to ensure the Trust's mortality data is timely, robust and in line with national and international best practice.

6) Ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.

7) Agree and oversee clinical coding improvements to address deficiencies evident from mortality / outlier investigations.

8) Assign clinical leads to address raised mortality or concerns within other benchmarked datasets in particular clinical services.

9) Receive reports on implementation and the measurable impact of defined interventions on hospital mortality.

10) Work with established groups to ensure each junior doctor intake receives the latest guidance on care protocol implementation (including the Care of the Deteriorating Patient) and clinical coding best practice.

11) Ensure the appropriate review and monitoring of compliance for an identified set of hospital polices impacting most on patient outcome, linking as needed to other monitoring Committees.

12) Ensure that assessed cases of avoidable mortality have been passed to the Incident Manager/ Incident Review Group so that an appropriate investigation can be initiated (building on the M&M review).

Summary duties for outlier review (as per the DORM Terms of Reference):

1) Develop and maintain a register of data sources addressing morbidity and mortality, this forming the basis for a schedule of data source review conducted by the Group.

2) Conduct necessary analysis / reporting to identify Trust performance, benchmarked against comparable peer organisation wherever appropriate.

3) Review National Clinical Audits and provide oversight to the established processes for addressing quality or data quality issues evident within.

4) Review reported data to establish if any outliers are apparent within the data and, where detected, establish the reasons for the outlier.

5) Assign actions, seeking the expertise of any Trust staff applicable to the issues detected who may assist to fully investigate / respond to the issue.

6) Maintain a clear record of actions identified and review the actions to ensure timely completion.

7) Escalate any significant issues as soon as they are identified, through the governance mechanism most suitable as judged amongst the Group.

8) Engage Clinical Directors and Clinical Service Leads in the Groups work and alert them to relevant issues to promote their leadership/oversight of actions.

9) Oversee/coordinate an effective response to any externally notified outlier. This includes all outlier alerts issued by the Care Quality Commission, Royal College or Society, or other relevant authority.

6.0 Reporting to the MSG

Reports will be collated by the GSU, primarily carried out by the Clinical Quality and Patient Safety Analyst, with support from the Compliance and Audit Manager / Head of Integrated Governance as needed.

Reporting will be supported by clear templates wherever appropriate. Specialty M&M Leads will be required to report relevant activity and issues to the Group.

7.0 Reporting Responsibilities

The minutes / log of actions of the MSG will be formally recorded and a summary provided to the Governance Committee as part of assurance reporting arrangements. The Chairman will highlight to the relevant Committee any item which requires their consideration.

8.0 Membership

Medical Director (Co-Chair)
Lead Clinician for Mortality (Co-Chair)
Information Services Representation
Deputy Director of Patient Care
Physician Representation
Surgical Representation
Emergency Department representation
Anaesthetist Representation
Junior Doctor Representation
GP representation
Head of Integrated Governance
Compliance and Audit Manager
Clinical Quality and Patient Safety Analyst (Secretariat)
Clinical Audit and Measurement Facilitator

In attendance
Head of Clinical Coding (co-opt to support with specific items)

The Chairman of the committee will be the Medical Director and Lead Clinician for Mortality jointly.

The Secretary will be the Clinical Quality and Patient Safety Analyst.

9.0 Attendance

Members are expected to attend all meetings. The standard for attendance for members is 80% of all meetings.

If a member cannot attend, they must send a fully briefed and empowered deputy.

10.0 Quorum

The meeting shall be quorate if the Chair or deputy and 3 other members are present, including at least one clinician. Any decisions taken at a meeting without a quorum must be verified with the wider membership.

11.0 Frequency of Meetings

The MSG shall meet monthly and ten times per annum as a minimum.

12.0 Accountability and Reporting

The MSG is accountable to the Governance Committee and reports via a routine annual report and by exception to the Quality Assurance Committee (QAC). In turn, exceptions will be raised to Governance Committee via QAC.

In addition, relevant items will be included as narrative within the integrated performance report to Trust Board. Externally, relevant reporting to NHS England will be established in line with requirements, once these are defined.

13.0 Review of Performance

The MSG will review its work and effectiveness annually. This will include review of duties, accountability, membership, attendance, reporting arrangements and arrangements for a quorum and frequency of meetings.

Updated 02-08-16 (LA)

APPENDIX B

Information for MPH Mortality Review (please complete both sides)

- Name of person completing form:_____
- Grade of person completing form:_____
- Team responsible for care at time of death:_____
- Surnames of consultants present at mortality review meeting:_____ _____

Patient initials		**Date of admission**	
MRN		**Date of death**	
Date of birth		**Ward at time of death**	

Description of case and any concerns (continue overleaf if needed)

If concerns with the patient's clinical care, please complete below

Area of care	Y/N	Specific issues or concerns
Preadmission care: GP/ambulance/other hospital		
Communication with patient/family		
Acute management (first 24 hours including ED)		
Out of hours care		
Seniority of decision making, are there issues?		
Diagnosis (misdiagnosis)		
Medication/fluid errors/ nutrition		
Issues around managing sepsis/ VTE?		
Investigations (problems with interpretation/delay)		
Escalation of care/ critical care		
Appropriateness of resuscitation/ TEP decisions?		
End of life care		

Death certificate: **1A**
1B
1C
2

We are tasked by NHS England to look at all mortality cases from two perspectives; avoidability of death and quality of care

Quality of care (please circle one). Research tells us that 10-15% of cases may have issues with quality of care. These are the standard grades developed with the M&M database which we have been using for the last 2-3 years

A. No significant care issues identified and care considered to be excellent despite the outcome
B. No significant care issues identified
C. Some care issues identified but not related to death
D. Care issues identified which may have contributed to death
E. Serious issues identified (failure to follow procedures/ unacceptable standards of care)

Avoidability of death (please ring one). Research tells us that in 2-4% of cases, death may be avoidable. This one is new – if you need to discuss, please come and find one of us

1. Unavoidable
2. Possibly avoidable but not very likely, less than 50-50
3. Probably avoidable, more than 50-50
4. Strong evidence for avoidability/ definitely avoidable

Considering the case overall

Are there any learning points?	Does there need to be action at directorate/ trust wide level (guidelines/ teaching etc). Please give details

Any comments/ improvements/ suggestions about this process please?

Appendix C

Briefing on coming developments

Current ongoing work to enhance and refine process defined in the main policy

Identification and selection of inpatient deaths for review:

a. By August 2018, identification of inpatient deaths will be through a level 1 review performed by the junior doctor at the time of certification. This will be a combined 'End of Life' and mortality review for all inpatient deaths. This will be on a purpose-built database which will feed cases through to the departmental mortality lead. The level 1 review will not only examine aspects of quality of care during the final admission but also, the quality of care around the patient's death with respect to gold standard principles expected for all 'expected' deaths in MPH.

b. The level 1 review will be completed by the addition of information from the bereavement team (highly experienced) after meeting with the family (and again after planned follow up phone consultations.) if applicable. This input from the family/friends at this stage will be key for focusing level 2 reviews and ensuring full engagement with the family/friends in the review process.

Review of inpatient deaths

a. By August 2018 automatic inclusion of death certification documentation will be electronically included in the level 1 review and will be automatically updated is further review required.

b. By august 2018, the review lists for each department will be populated following level 1 reviews. A digital programme should also allow an improved ability to feedback to departmental mortality meetings/leads and ensure cases are discussed in all appropriate mortality meetings (as appropriate). The formulation of this pending list will allow allocation of mortality reviews to departments and ensure that appropriate timing/resource allocation is allotted to ensure the appropriate depth review is undertaken. Work has already been undertaken to identify the clinical mortality groupings and work is underway to examine the volume of mortality review in each of these groups to aid job planning and resource allocation.

c. The use of a digital programme will also aid the use of mortality data (and indeed mortality review(s) data) to be used as part of a individual consultant's appraisal.

d. In October 2017, the RCP in conjunction with the West of England AHSN will be undertaking SJR training in MPH. Following this training formal decision will be made (via the MSG) about whether to adopt this process for structured case review.

Need for further investigation and dissemination of learning from inpatient deaths

a. By November 2018, output from mortality review cases will be thematically recorded in a computerised format. Work is already underway to log the mortality forms electronically so that they can be retrieved for thematic analysis and cross-departmental review.