The Royal Liverpool and
Broadgreen University Hospitals
NHS
NHS Trust

Trust Policy

Governance Department

Policy for the Review of Trust Mortality

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1.0 Introduction

A peer review of each and every death in the Trust is required to ensure we have provided the highest quality of patient care or that lessons are learned and disseminated across the organisation if we have not. Documentation pertaining to each death should be escalated through the directorate and divisional structure, via the Clinical Governance route.

2.0 Objective

The objective of this policy is to ensure a robust system is in place across the organisation to review and manage all deaths appropriately occurring in the Trust, be they expected or not; to provide assurance the highest quality of patient care was provided at all times and any shortfall identified is escalated and lessons learned disseminated widely. The essence of the review process will be the same across all two bed-holding divisions of the Trust, and will be managed through three varied facets, managed and coordinated by the overarching Deterioration and Mortality Group (DMG);

- Mortality Peer Review
- Mortality Quality Assurance Group
- Mortality Alert Group

3.0 Scope of Policy

This policy should be viewed by all employees in the organisation who have been involved in the care of a deceased patient, including but not exclusive to junior and senior medical staff, directorate and divisional managers, matrons, ward managers, members of staff in the bereavement office and members of staff in the Effectiveness Team.

4.0 Policy

Reviews will be undertaken for all deaths occurring in the hospital. The process will be initiated, electronically, in the Bereavement Office when demographic and overview information will be pulled through from iPM – (Part A of the review tool).   Following discussion with a senior clinician, Part B of the tool will be completed, again electronically, by the certifying doctor.

The Effectiveness Team will liaise with the Coroner's Office to capture details of deaths not certificated on site, complete section B of the database and notify the directorate accordingly.

At directorate level:

- ➢ Each review should be consultant-led
- ➢ Consultants should not review their "own" cases, whether or not they were personally involved in the patient's care
- ➢ The review should be documented in meeting notes
- ➢ The review should be formative but challenging for the purposes of continuous improvement.

> ➤ Lessons learned should be clearly documented and escalated.

The Effectiveness Team will compile monthly summary reports of peer review activity for submission to directorate leads and appropriate governance and performance review meetings. If a directorate level peer review identifies the need for a cross directorate/divisional multidisciplinary team (MDT) review; the patient safety team (on behalf of Deterioration and Mortality Group) will co-ordinate this. These will be scheduled on a fortnightly basis, but convened more urgently if circumstances dictate.

Notes will be taken at this meeting with action plans developed as appropriate. These will be circulated to all present at the meeting, in addition to the Medical Director, Divisional Clinical Directors and Patient Safety Leads, the latter will review to identify possible trends.

The Deterioration and Mortality Group will compile lessons learned summaries and will work with the Patient Safety Leads and Communications Team to communicate these. When considered necessary, the Patient Safety Leads will commission audit to ensure and evidence lessons have indeed been learned.

As from January 2015, reviews can ascertain whether or not a death was not preventable or possibly preventable, and this will form part of the electronic database. Those who feel that the death was possibly preventable are able to add further comments to support this.

4.1 Mortality Quality Assurance Group.

The above group has been formed to provide Board with assurance regarding the the effectiveness of the Mortality Peer Review process. The group will;
- initially review a random sample of cases that have been through the review process.
- review the case and compare this with the directorates findings. In order to
- assess the quality of care provided, by scoring against the NCEPOD quality of care, and also utilise Likert's scale of preventability.
- will ascertain lessons learned and whether the group agree with initial findings.

The process is currently being trialled and it is intended that all possibly preventable cases will be reviewed and also a random sample of 10% of the not preventable mortality cases.

4.2 Mortality Alert Group

The Mortality Alert Group will oversee the system and process for the reporting of procedural, diagnostic, mortality and the new patient safety related alerts

To make informed decisions in response to alerts as to whether the following should be undertaken;

- Observation of alert
- Conduct a casenote review
- Undertake a Coding Audit
- Undertake Full Clinical Audit

Each alert will be discussed openly and will be supported by robust corporate information and followed by a clear plan of action for the clinical speciality to undertake.

The group will manage, monitor and audit (where applicable) alerts from other external agencies e.g CQC, Monitor.

Utilising the tools provided Dr Foster, the group will also proactively review diagnosis that are are alerting at a lower confidence level of 90.

In addition to this, general performance relating to HSMR (Hospital Standardised Mortality Ratio), SHMI (Summary Hospital-level Mortality Indicator), and crude mortality will be monitored.

4.3 Reporting

See Appendix 4

5.0 Roles and Responsibilities
The Effectiveness Team with the Deterioration and Mortality Group will have oversight of the review process.

5.1 Directorate Clinical Governance/Mortality/Patient Safety Leads
- Should ensure there are timetabled Mortality and Morbidity review meetings within their directorate, these are minuted and minutes submitted to their directorate Clinical Governance Meeting.
- A quarterly summary of discussion and pertinent items from these meetings is submitted to the Medical Director, Effectiveness Team and Deterioration and Mortality Group.
- A process is in-place to allocate an appropriate peer to review each death within the mandated timeframe (i.e. within 30 days of death) and details recorded on the mortality section of the Effectiveness Database accordingly.
- This policy is communicated to all consultant and junior medical staff.

5.2 Divisional General Managers
Are responsible for ensuring mortality peer review is a standing item on directorate performance review meetings and a regular item on divisional quality governance meeting agenda. They are also responsible for escalating issues of concern to the Deterioration and Mortality Group.

5.3 Directorate Managers

Are responsible for ensuring minutes of Directorate Mortality and Morbidity meetings are received by their directorate governance meeting.
Putting arrangements in place to collect case sheets from the Resuscitation Office (12th floor) each Monday and ensure appropriate tracking takes place.

5.4 Trust Effectiveness Team
Responsible for oversight of the peer review process, liaison with the Coroner's Office and compiling monthly activity reports.

5.5 Bereavement Office
Staff in the Bereavement Office will be responsible for initiating the review process by generating section A of the electronic record.   They will also liaise with the certifying doctor to ensure section B is completed.

Staff in the Bereavement Office will not allow case-sheets to be removed for any other reason than mortality peer review.   Case-sheets will remain in the Bereavement for a maximum of two weeks following death (to facilitate coding and filing of care pathways). They will be transferred, on a weekly basis (a week in arrears) to the Resuscitation Office.

5.6 Associate Medical Director for Medical Education
Responsible for ensuring all junior doctors receive and acknowledge receipt of training on this policy.

5.7 Patient Safety Leads
Will be responsible for reviewing summary reports and action plans to identify summary trends.

6.0 Associated documentation and references
This policy should be read in conjunction with:-

- Do Not Attempt Resuscitation (DNAR) policy
- National Early Warning Score (NEWS) escalation for the deteriorating patient (including Surviving Sepsis protocol)
- Infection Control Policy

7.0 Training & Resources
Junior doctors will receive training on this policy as part of the induction process, both Trust Wide and locally.

8.0 Monitoring and Audit
Adherence to this policy will be monitored via the Deterioration and Mortality Group.

Overview reports of lessons learned will be distributed to appropriate directorate, divisional and Trust governance meetings on a quarterly basis.

9.0   Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full Equality Impact Analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1   Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover all strands of equality legislation and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

Appendix 1

Glossary of Terms used within the Policy

DNAR: Do not Attempt Resuscitation
NEWS: National Early Warning Score
ET: Effectiveness Team

Appendix 2 Screen shots

Part A: Patient Information

Part B: Death Certification

Mortality Peer Review

The Royal Liverpool and **NHS**
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NHS Trust

| Home | User Admin | Log Out |

| Part A: Patient Information | Part B: Death Certification | Part C: Peer Review |

⚠ Please remember to submit this form using the submit button at the end of the section.

Name of doctor completing certification

Grade of doctor completing certificate

Have you discussed the death certification entry with your supervising consultant? (Every effort should be made to do so to ensure accurate entries)?
○ Yes ○ No

Death certification entries:- Ia

Death certification entries:- Ib

Death certification entries:- Ic

Death certification entries:- II

Was the death referred to the coroner?
○ Yes ○ No

[Submit Section B]

[⊗ Delete]   [Save as Draft Record]

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Part C: Peer Review

Part C (continued); If death was deemed Possibly Preventable

Part C (continued): If the death needs to be referred to a cross-directorate Multi-Disciplinary Team meeting

Mortality Peer Review

The Royal Liverpool and **NHS**
Broadgreen University Hospitals
NHS Trust

Home   User Admin   Log Out

| Part A: Patient Information | Part B: Death Certification | Part C: Peer Review |

⚠ Please remember to submit this form using the submit button at the end of the section.

Please give a brief summary of the circumstances surrounding this patient's admission and death.

Was this death?
○ Possibly Preventable   ○ Not Preventable

What, if any, lessons can be learned from this patient's, care and how was this death preventable? (Specific lessons which can be shared across the organisation.)

Please select Lesson learned category

Select ▼

Specific comments from Critical Care Unit (if applicable)

Does this death need to be referred to a cross-directorate Multi-Disciplinary Team meeting?
○ Yes   ○ No

If Yes, please state reason/s why?

If yes, please state the directorates and, if known, representatives who should be invited to attend:

1. Select ▼
2. Select ▼
3. Select ▼
4. Select ▼
5. Select ▼

Form reviewed by
Consultant only (who peer reviewed this case)

Date Reviewed

Submit Section C

⊘ Delete

Save as Draft Record

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Appendix 3 Mortality Peer Review Process

Mortality Peer Review Process

Duration

Bereavement

RIP

↓

Bereavement office collate a list of mortalities from the mortuary list.

↓

Bereavement office collect all case notes (C/N).

↓

Casenotes sent to Coroner's office ← Y — Are the casenotes required for the coroner? — 2 weeks

↓ N

Bereavement officer initiates Part A of yellow form electronically on mortality database.

↓

Junior Doctor discusses with senior clinician and completes Part B electronically on mortality database.

↓

Each Friday, case-notes for the previous week's deceased delivered to Resuscitation Team Office, 12th Floor. Bereavement Office record notes despatched on iPM.

Directorate

Resuscitation Team record case sheets as received on iPM and send generic e-mail to mortality leads advising case-sheets are available for collection

↓

Directorate clerical/ward staff collect case sheets. Resuscitation Team record despatch on iPM, directorate staff record receipt.

↓

Each Directiorate may have their own way of dealing with MPRs internally at tbis point

Directorate pass to relevant clinician peer to review and complete Part C of the mortality database electronically within 30 days of death. — 2 weeks

↓

Clinician PEER decides whether a cross directorate peer review is appropriate and completes request on mortality database.

↓   ↓

MDT required   MDT not required

↓   ↓

MDT

Effectiveness Team coordinate the MDT.   Effectiveness team alerted an MPR complete and form report.

↓

MDT chaired by Patient Safety lead clinician.

↓   Email trigger sent to clinical director and directorate governance lead with appropriate escalation

Lessons learned discussed and SMART action plan agreed.

MAPS

Overview of MPRs and all outcomes of all MDTs discussed, with actions monitored. — 2 weeks — Is the MPR late?

BOARD

Report compiled monthly for Board and Governance Committee. ← N

Appendix 4

Mortality reporting arrangements

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                    │            TRUST BOARD              │
                    └─────────────────────────────────────┘
                                     ▲
                                     │
                    ┌─────────────────────────────────────┐
                    │   QUALITY GOVERNANCE COMMITTEE      │
                    └─────────────────────────────────────┘
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| PATIENT EXPERIENCE | DIVISIONAL GOVERNANCE | PATIENT SAFETY | CLINICAL EFFECTIVENESS |

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                                    Deterioration
                                    and Mortality
                                    Group

Multi-disciplinary        Mortality              Mortality Alert
Mortality and             Quality                Group
Morbidity                 Assurance
meetings                  Group

Divisional
Mortality and
Morbidity
meetings
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Appendix 5

Document History and Version Control for Development of Trust Policies, Protocols and Procedures

Version	Date	Comments	Author
0.1	May 12	Circulated to members of the Cross Divisional Meeting for review and comment and updated accordingly.	S Byrne (Effectiveness Lead)
1	June 12	Circulated to all those identified with responsibility within the document for review and comment and updated accordingly.	S Byrne (Effectiveness Lead)
1.1	Oct 13	Updated in response to feedback/change in practice.	D Corness (Effectiveness Officer)
1.2	Nov 13	Updated due to formation of MAPS Sub-committee and appointment of Patient Safety Leads and subsequent discussion.	A Duffy (Senior Lean Practitioner)
1.3	Nov 13	Submitted to MAPS for review	A Duffy (Senior Lean Practitioner)
1.4	Feb 15	Updated to reflect change in terminology and responsibilities.	S Byrne (Effectiveness Lead)
2	Feb 15	To include other aspects of Mortality reporting	A Duffy (Senior Lean Practitioner)
3	March 17	No changes	A Banks

Review Process Prior to Ratification:

Name of Group/Department/Specialist Committee	Date
Clinical Effectiveness Sub-Committee	
Deterioration and Mortality Group	06.03.15
Patient Safety Sub Committee	