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The Pennine Acute Hospitals NHS
NHS Trust

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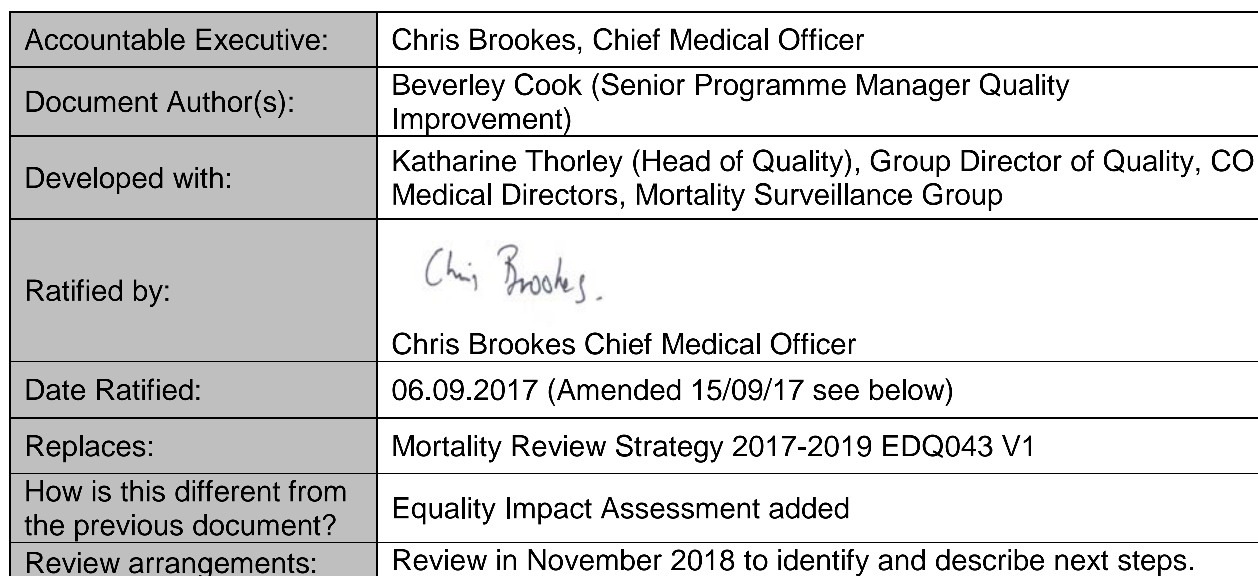
Mortality Review Strategy 2017-2019

What is this document for?	The purpose of this strategy is to outline the plan to ensure the trust is fully appraised of its mortality information: the published standardised mortality rates, and the key themes emerging from mortality reviews. Ultimately the trust aims to have no cases of avoidable mortality. Two processes are central to achieving this: reviewing cases to identify where patients' care has not met the expected standard and any factors contributing to deaths that could have been avoided; and implementing measures to prevent such shortfalls recurring in the future. Additionally, the strategy will ensure the publicised standardised mortality rates accurately reflect the situation in each of the care organisations.
Who needs to know?	Clinical and managerial leads at care organisation, divisional, directorate and speciality level, all staff directly involved in delivery and organisation of patient care, information and coding teams, commissioning groups.
Related PAT Documents:	Quality Strategy (EDQ037) Risk Management Strategy and Policy (EDQ012); End of Life Care Strategy and Policy – (under review)
Related Legislation/ Obligations/Trust Objectives:	Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016) National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, March 2017) Royal College of Physicians National Mortality Case Record Review Programme NHSE Serious Incident Framework - supporting learning to prevent recurrence



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Replaces:	Mortality Review Strategy 2017-2019 EDQ043 V1
How is this different from the previous document?	Equality Impact Assessment added
Review arrangements:	Review in November 2018 to identify and describe next steps.

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Mortality Review Strategy 2017-2019

1. Our Vision

'To ensure that case reviews of patients that have died are used to support the delivery of harm-free care within the trust.

To know and understand the position in the trust relating to mortality – the published standardised mortality rates, and the key themes emerging from mortality reviews that might be influencing these.

To eliminate cases of avoidable mortality within the trust by identifying potentially avoidable factors that have contributed to patients' deaths and implementing remedial measures to support the fundamentals of care and to prevent these factors recurring in the future.'

Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust are committed to undertaking a proportionate review of all cases where patients have died, recognising where the organisation or delivery of patients' care could have been better, and making the appropriate changes to deliver improvements. The vision underpinning this strategy is to ensure high-quality review of cases of mortality, and lessons learned as a result, are embedded in the trust's clinical governance framework.

This strategy is a component of the group's overall quality improvement strategy. It will contribute to the provision of high quality care for patients that is safe and effective, with an experience that meets or exceeds their expectations.

2. Our Goals

The aim of the strategy is for there to be an effective mortality review programme in place that identifies areas for improvement, and an effective governance structure that monitors delivery of improvements. In turn, and together with a focus on complete and accurate clinical documentation and coding, this should reduce the care organisations' standardised mortality rates.

The goals are to ensure that:

1. There is an appropriate and proportionate review of all mortality within the trust:
   - 1.1 all cases where patients have died are reviewed by a multi-disciplinary speciality team in accordance with national guidance and the trust policy, an 'avoidability' score is assigned, and cases are escalated for further review or investigation where concerns are identified;
   - 1.2 a separate and independent 'corporate' review process is in place that provides additional assurance and ensures the trust is compliant with national guidelines;
   - 1.3 mortality rates are monitored closely to identify trends and areas of emerging concern
   - 1.4 special reviews, e.g. "cluster" reviews are undertaken in response to review of information where necessary

2. findings from all mortality reviews are shared for learning at the appropriate level within the division, care organisation or group (as applicable) to celebrate and share good practice, and to ensure that risks are identified and acted on within the clinical governance framework;

3. where mortality reviews have shown that care falls short of the agreed standard, focused actions are identified to improve care and service delivery, an action plan is drawn up and agreed, and its delivery is monitored and subsequently audited where appropriate;

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4. resource for mortality review is used effectively, and training and support is available for staff involved in the review process;

5. processes are in place to support accurate and thorough clinical documentation and coding – these include templates, systems, and training; and

6. there is clear accountability, and governance of the mortality review and learning process is in accordance with best practice and sits within the overall clinical governance framework.

Each of these goals has its own work-streams.

3. How we will drive and enable change

3.1 Mortality Reviews

We will have a comprehensive programme of review of cases of mortality, and of mortality statistics, across all care organisations. This will have four main areas of work.

3.1.1 Speciality reviews

The cases of all patients that have died will be reviewed by the speciality, and a provisional avoidability score assigned. For specialities with a large number of deaths where this is not yet possible, priority will be given to reviewing the deaths identified as priority in the National Quality Board guidance (March 2017). Where specific guidance exists for specific patient groups e.g. neonates or maternity, this will be incorporated within the trust's speciality review processes.

Reviews will be multi-disciplinary and not conducted by a single doctor, and not be led by a doctor closely involved in the case. Patients' relatives will be enabled to participate in the review if they wish by linking with the bereavement teams.

Cases assessed as more serious than "slight evidence of avoidability" will be escalated for a second review by the independent corporate team. Cases will be discussed at local M&M meetings, during which the meeting will agree the provisional avoidability score, and identify appropriate actions to address any untoward findings.

3.1.2 Corporate review programme

A separate programme of independent mortality reviews will complement the speciality reviews and to provide additional assurance. This has been in place trust-wide since August 2015, but will become care organisation-based when possible. These reviews will be conducted using the Royal College of Physicians' "structured judgement review" methodology. Cases will be selected for independent review in accordance with national guidance, and as outlined in the mortality review policy (see appendix 2).

Additionally, mortality investigations will be undertaken in more serious cases. A process and template will be agreed for this, which will link closely with the serious incident framework, duty of candour processes, and the inquest management process. Patients' relatives will be invited to be involved in any investigation to the extent they wish to be.

3.1.3 Review of Mortality Indices

We will ensure that electronic information systems (e.g. Dr Foster Quality Investigator, NHS Digital) are routinely monitored and scrutinised, and relevant information reported and any alerts actioned appropriately.

Clinical and managerial leads from each directorate or speciality within the care organisations will work with the information team to review the information, and investigate any areas of concern to

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identify any actions required or to provide assurance. Likewise, the corporate information team will review and monitor information to maintain an overview.

The review of mortality indices will also enable the impact that any organisational, service or process change may have on mortality rates.

3.1.4 Cluster Reviews

Reviews of clusters of cases will be undertaken in an appropriate timeframe when the need is identified. This might be as a result of conditions alerting on information systems, or if concerns have been identified from other sources.

3.2 Sharing Findings from Mortality Reviews

3.2.1 Process for sharing findings

Findings from reviews will be shared, where relevant, within and across specialities, care organisations, and the trust. Sharing of findings will be targeted and proportionate, with indiscriminate sharing being discouraged.

There will be a consistent approach to sharing of findings, in a straightforward style and format that staff will immediately recognise, which includes all the relevant information.

3.2.2 Lessons Learned Framework

Findings from mortality reviews will be incorporated within the trust's lessons learned framework, which will embrace lessons learned lessons from all sources, including complaints, serious incident investigations, inquest findings, and clinical audit.

3.3 Action planning and improvement

We will aim to ensure that actions identified from mortality reviews are implemented to improve quality of care and service delivery. Any serious risks identified will be escalated appropriately, in accordance with the risk escalation process, and any immediate actions will be taken. Formal risk assessment for inclusion on the relevant risk register may be required.

For further information, please refer to the Trust's Risk Management Strategy (EDQ012): http://nm-ashanti:86/DMS/DesktopModules/WroxDocs/ViewDocument.aspx?ItemID=95&mid=15242&key=95

3.3.1 Process for agreeing recommendations and identifying actions

Findings from mortality reviews from all sources will be reviewed by staff, teams and meetings at the appropriate level in the trust, as described in the mortality review policy. Where shortfalls in patient care or service delivery have been identified, then recommendations for improvement will be proposed, discussed and agreed.

Action plans will reflect the findings from the review (and any associated issues) with actions that will result in the desired outcome. Actions will be SMART (specific, measurable, achievable, relevant and time-specified) and will have a named action owner.

Issues will be escalated where necessary (e.g. escalated from speciality meeting to care organisation meeting) for discussion to be held and decisions made at the level in the organisation that has the authority to implement the required actions and monitor progress. Ownership of an action will be transferred where appropriate, with agreement of both parties.

3.3.2 Monitoring implementation of actions

Progress of the implementation of action plans will be monitored to completion, by the appropriate team, group, or formal meeting, and relevant evidence will be collated to support this. Progress will be reported at timescales agreed, and any delays that cannot be managed by the monitoring group will be escalated accordingly within the governance and managerial frameworks.

3.4 Resource, Training and Support

Mortality reviews will be conducted in accordance with best practice, by the appropriate staff, who have had training to do so.

3.4.1 Structured Judgement Review methodology training

We will work towards all mortality case reviews being undertaken using this methodology. A prioritised cascade training programme in SJR will be devised and delivered. Staff will be mentored with their first reviews, as appropriate to their needs.

3.4.2 Multidisciplinary

Staff across all clinical professions will be assisted to develop sufficient skill and knowledge to undertake or contribute to mortality reviews, and be supported to lead and manage improvement activities arising as a result. Care organisation leads will monitor numbers of corporate reviewers and ensure appropriate deputies / succession planning is in place.

3.4.3 Job planning

Staff undertaking mortality reviews within their speciality, and those participating in the corporate independent review programme, will be supported to do so with sufficient time being allocated within their job plan / existing responsibilities. This is so that reviews can be undertaken within the defined time-frames to maximise the benefits obtained from the findings and implementation of actions.

3.4.4 Information systems training

Appropriate training in the use of Dr Foster and other any relevant information systems will be prioritised for staff with responsibilities for providing or reviewing information, and those clinicians named as core mortality reviewers.

Clinical directors will determine which additional staff need to have training on, and access to, the systems.

3.5 Clinical Documentation and Coding

Clinical documentation will be correct and fully completed, so that accurate coding following a patient's death can be undertaken promptly. This will ensure that information submitted to external systems, which is used to calculate standardised mortality rates and areas of concern, is accurate.

3.6.1 Review of deceased patients' records and coding

A process to ensure that patients' final episodes of care are documented and coded accurately will be agreed, described in the mortality review policy, and implemented across all specialties within the care organisations. This will include appropriate and achievable time-scales.

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3.5.2 Preliminary review of data

The support team from Dr Foster will review the provisional information submitted by the care organisations for any potential anomalies or areas of concern, and flag these to the trust. This will enable additional verifying to be undertaken to identify and correct any errors before it is formally and finally submitted to NHS Digital.

3.5.3 Training and awareness

The importance of the accuracy of clinical documentation, including the specific terminology that must be used to achieve the most accurate coding, will continue to be a focus.

Documentation and coding training will be established for junior doctors as part of their on-going education programme.

Documentation and coding will be included as a core agenda item for the directorate / speciality mortality meetings (or mortality component of clinical governance meetings). This will include a short report of coding performance to the meetings, and any communications / best practice updates.

3.6 Accountability, Governance and Assurance

3.6.1 Speciality M&M meetings

Each speciality / directorate in the care organisations will conduct mortality and morbidity meetings in accordance with the minimum core agenda as outlined in the mortality review policy. Attendance at M&M meetings will be multidisciplinary, to include nurses and allied health professionals as well as doctors and managers.

Specialities with a small number of deaths will present and discuss all their cases: those with larger numbers of deaths will present those causing concern individually, and summarise any themes identified from the other cases. Appropriate recommendations and actions will be agreed following discussion, and progress of actions monitored at subsequent meetings.

Meetings will be appropriately minuted to record proceedings and actions. The clinical director or speciality lead (depending on the level of the meeting) is accountable for the conduct and outputs of the meeting, including the delivery of actions (or escalation).

3.6.2 Mortality Surveillance Groups at CO and trust level

Effective and proactive Mortality Surveillance Groups will be established at each care organisation. These groups will report to the care organisations' Clinical Effectiveness Committees, and to the trust-wide Mortality Surveillance Group (or as agreed within the developing CO governance structures). See appendix 3 for the proposed mortality review governance structure.

These groups will oversee the implementation of this strategy and associated policy, and ensure that learning can be demonstrated, or exceptions appropriately escalated.

Representatives from the CCGs will be invited, to facilitate effective partnership working in resolving issues involving the wider health economy.

3.6.3 Reporting of information

Systems and processes will be developed to ensure the trust is compliant with the guidance for reporting to the board and externally, including reporting in the trust's Quality Account in 2017-18.

This will include quantitative information relating to the numbers of deaths, avoidability scores,

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and themes; and qualitative information relating to improvement actions. The national dashboard, when available, will be incorporated within this.

4. How we will measure progress

The following table outlines the measures that will indicate to us that the strategy is effective:

Indicator	Assessed by
4.1 Mortality Review	
All cases of mortality will be reviewed by the speciality; findings discussed at M&M meetings.	Records of case reviews completed M&M meeting minutes
All reviews are multidisciplinary.	Recorded on review form and monitored
Patients' relatives to be involved if they wish.	Recorded on review form and monitored
Speciality reviews escalated for independent review according to the avoidability score.	Recorded on review form and monitored
Corporate review programme using SJR of cases identified from escalation and according to policy.	Completed reviews retained and monitored Monthly thematic report
Review of mortality indices.	Monthly report of data, including actions taken and findings
Cluster reviews are undertaken when indicated.	Minutes of meetings commissioning and receiving reports. Reports of findings
4.2 Sharing Findings from Mortality Reviews	
There will be a consistent approach to the sharing of mortality review findings across the Trust.	Review findings are presented in the approved document or PowerPoint template.
Lessons learned framework set out and implemented across the care organisations and trust.	Framework approved and in place Evidence of implementation (as determined by framework)
4.3 Action Planning and Improvement	
Where shortfalls in patient care or service delivery have been identified, then recommendations for improvement will be proposed, discussed and agreed.	Copies of action plans held at the appropriate level (for implementation monitoring).
Actions monitored to completion (or escalated if beyond the remint of the responsible group)	Minutes of M&M / Mortality Surveillance Group meetings. Completed action plans.
Managers and clinicians assigned to an action will be held to account for its delivery within the agreed timescale.	Minutes of meetings / reports where progress of plans is reported.
4.4 Resource, Training and Support	
All clinical professional staff involved in mortality review will have training in Structured Judgement Review methodology and a period of mentorship if required.	Training records
Sufficient core mortality reviewers (multidisciplinary) for each care organisation will have time within their roles to conduct independent mortality reviews and fulfil the corporate mortality review process	Timely reviews completed Reports available

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Staff receive appropriate training on information systems to fulfil their role requirements.	Accurate reporting and review of information in place.
	Monthly reports by speciality / directorate to MSG
4.5 Clinical Documentation and Coding	
Process agreed and implemented for review of deceased patients' notes and coding	All coding for deceased patients is completed within the agreed timeframe – performance reports.
Regular scheduled review of provisional information by Dr Foster support team, with feedback	Communications to information teams and clinicians
Documentation and coding training established on junior doctor education programme	Programme records
Documentation and coding on agenda for M&M meetings, with update reports	Coding performance reports
	Minutes of meetings
4.6 Accountability, Governance and Assurance	
Speciality / directorate M&M meetings, covering all clinical areas of the COs, are in place at least bi-monthly and comply with the minimum core agenda.	Schedule / minutes of meetings
Attendance at meetings is multi-disciplinary. Managers will support nurses and AHPs to be able to participate	Records of attendance
Recommendations agreed at the meeting are incorporated within action plans.	Minutes of meetings, action plans
Action plans are monitored to completion or escalated	Minutes of meetings, action plans
Mortality Surveillance groups are established in each CO	ToR, membership and agenda / minutes available
Regular mortality reports (quantitative and qualitative information) reported to the Board of Directors and compliant with national guidance	Board minutes, mortality reports

5. Our Projected Timescales

The following table sets out the milestones for 2017. This will be reviewed in December 2017 and milestones for 2018 set, in relation to progress made and further improvement actions identified.

Key milestone	Due date
5.1 Mortality Review	
All specialities / directorates to review all deaths identified as priority in the National Quality Board guidance (March 2017).	from August 2017 (July deaths)
All specialities / directorates to identify requirements needed to undertake proportionate multidisciplinary review of all cases of mortality, and be working to a plan to have this in place by April 2018.	end August 2017
Corporate mortality review programme in place, in accordance with mortality review policy, in each of the COs	from August 2017
Mortality investigation process, linking with the SI and inquest processes, will be in place for the most serious cases.	from September 2017
Process is established to support involvement of patients' families in the reviews if they wish	from September 2017
Regular review and scrutiny of information systems and monthly report in place	from July 2017

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5.2 Sharing Findings from Mortality Reviews	
Agreed consistent approach to sharing findings – approved templates are used at M&M meetings.	from July 2017
Learning lessons framework in place across COs and the trust	from October 2017
5.3 Action Planning and Improvement	
Action plan template agreed and in place	from July 2017
Appropriate recommendations drawn from review findings and translated into specific action plans	from July 2017
Evidence of monitoring of action plans across all specialities / directorates	from September 2017
5.4 Resource, Training and Support	
All COs to identify reviewers (multidisciplinary) for their corporate independent review teams	end July 2017
SJR training completed for all core CO reviewers	end October 2017
All specialities / directorates to identify reviewers (multidisciplinary) to undertake local reviews	end July 2017
SJR training completed for all speciality / directorate reviewers (multidisciplinary)	end December 2017
Training needs analysis for information systems to be completed for each CO based on job roles	end July 2017
Information systems training completed for essential users	end October 2017
5.5 Clinical Documentation and Coding	
Process / time-frame agreed for notes review / coding following a patient's death	end July 2017
Process fully implemented across all specialities / directorates / COs	end August 2017
Process established for Dr Foster "early warning review" of provisional information	from July 2017
Documentation and training included in junior doctors' on-going education programme	from August 2017
Documentation and coding established as core agenda item M&M meetings	from July 2017
Regular coding performance and update report (by CO / directorate) is in place reporting to M&M meetings	from September 2017
5.6 Accountability, Governance and Assurance	
Each speciality / directorate is conducing M&M meetings in accordance with policy, including multidisciplinary attendance and minimum core agenda	from July 2017
Each CO to have an effective MSG meeting with ToR and membership agreed	from September 2017
Information systems in place to support reporting to the BoD in accordance with national guidance	from September 2017

6. How we will engage with our staff, patients and other stakeholders

6.1 The Trust supports the involvement of patients' family and carers in the mortality review and learning process. This will be facilitated through the bereavement centres being established in each CO, and through the duty of candour and inquest processes, where applicable.

6.2 Multi-disciplinary and cross-organisational working are hallmarks of good clinical governance. The group encourages joint reviews / investigations where appropriate, and sharing of review findings across the care organisations.

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6.3 Representatives from the CCGs will attend the Mortality Surveillance Groups.

6.4 Staff are actively encouraged and enabled to attend M&M and be involved in reviews and implementation of improvement actions.

7. How we will communicate our strategy & progress

7.1 We will develop and establish formal communication links to ensure that staff at all levels are aware of the processes and plans.

7.2 We will provide an update of progress in each care organisation to the local and group Mortality Surveillance Groups.

7.3 We will develop and maintain communication with commissioning bodies and with other Health economy partners and organisations.

7.4 We will develop mechanisms for promotion of learning from mortality across the care organisations by:

- encouraging participation in multidisciplinary case reviews and discussion of findings;
- maintain awareness of the mortality review and learning process by publicising relevant outcomes, improvements and reports

8. How you can share your views

8.1 You can share you views by contacting the care organisation mortality leads:

- Fairfield General Hospital / Rochdale Infirmary: sweta.pradhan@pat.nhs.uk
- North Manchester General Hospital: anton.sinniah@pat.nhs.uk
- Royal Oldham Hospital: GeorgesNgManKwong@pat.nhs.uk
- Salford Royal Hospital: timothy.fudge@srft.nhs.uk

8.2 You can contact the clinical governance leads in the care organisations.

9. Appendices

9.1 Equality Impact Assessment
9.2 Mortality Review Process
9.3 Mortality Review Governance structure

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Appendix 1 – Equality Impact Assessment

The Pennine Acute Hospitals NHS
NHS Trust

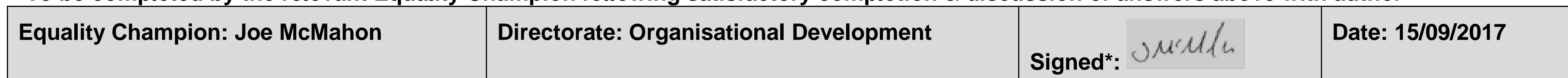
Equality Impact Assessment for Mortality Review Strategy EDQ043 V1.1

To be completed by the Lead Author (or a delegated staff member)

For each of the Protected Characteristics & equality & diversity streams listed answer the questions below using Y to indicate yes and N to indicate no:	**Age**	**Disability**	**Ethnicity / Race**	**Gender**	**Gender Reassignment**	**Marriage & Civil Partnership**	**Pregnancy & Maternity**	**Religion/belief**	**Sexual orientation**	**Human Rights**	**Carers**	Please explain your justification
1. Does the practice covered have the potential to affect individuals or communities differently or disproportionately, either positively or negatively (including discrimination)?	N	Y	N	N	N	N	Y	N	N	N	N	All deaths will be treated the same, however, some mortality reviews will be triggered immediately as per the national guidance e.g. learning disabilities, elective patients, Maternal or neonatal deaths.
2. Is there potential for, or evidence that, the proposed practice will promote equality of opportunity for all and promote good relations with different groups?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The Mortality Review Strategy provides a single pathway for all mortality reviews therefore treats all groups equally and promotes good practice for all.
3. Is there public concern (including media, academic, voluntary or sector specific interest) in the document about actual, perceived or potential discrimination about a particular community?	N	N	N	N	N	N	N	N	N	N	N	The Mortality review strategy provides a review process for all patients who die in hospital therefore the public should have no concern over discrimination.

Your Name: Beverley Cook	**Your Designation: Senior Programme Manager QI**	**Signed*:**	**Date: 14/09/2017**

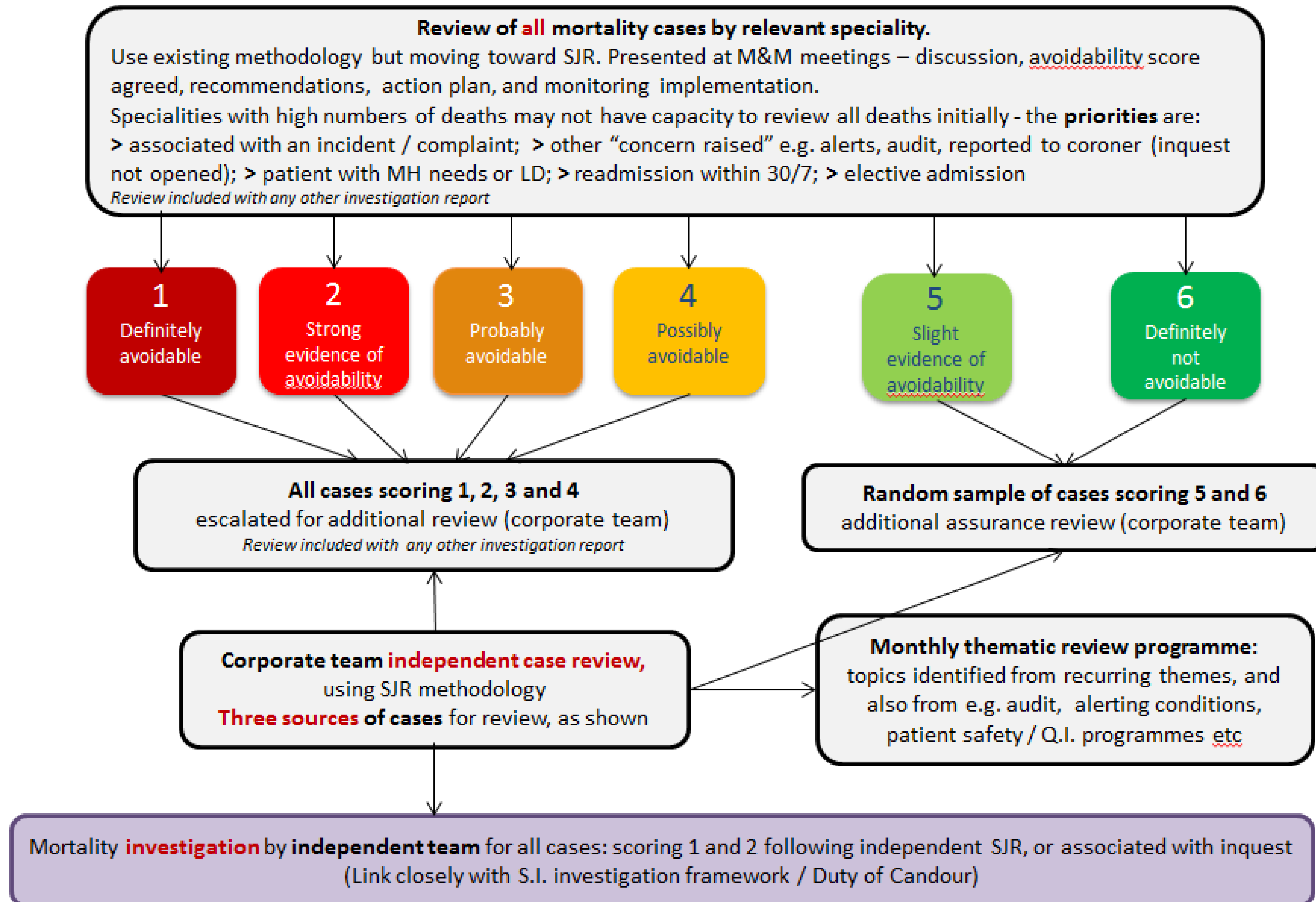
To be completed by the relevant Equality Champion following satisfactory completion & discussion of answers above with author



Equality Champion: Joe McMahon	**Directorate: Organisational Development**	**Signed*:**	**Date: 15/09/2017**

*Please scan or insert electronic signature

Appendix 2: Mortality review process



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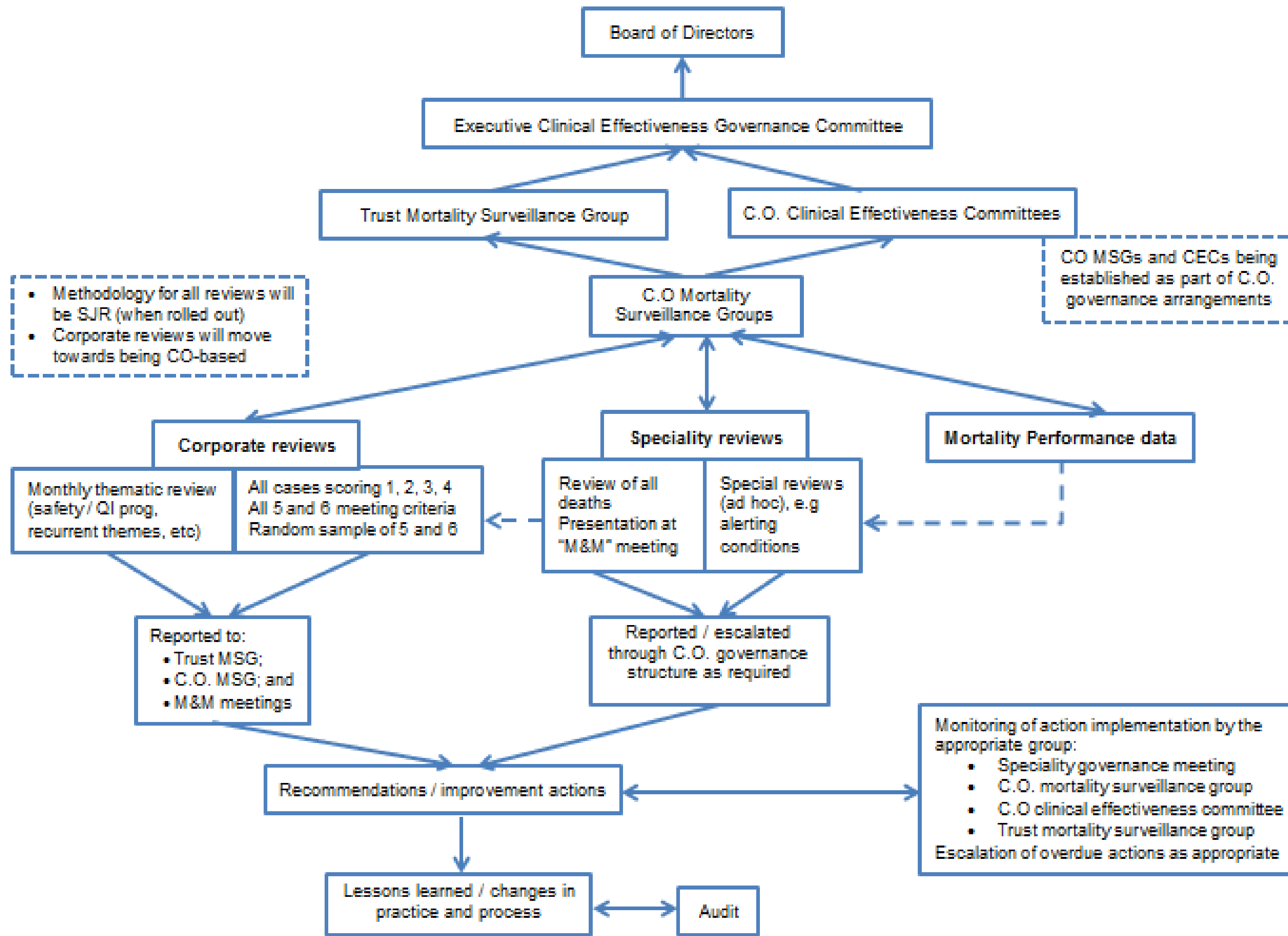
Appendix 3: Mortality review governance structure



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