# POLICY ON MORTALITY REVIEW PROCESS

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<td>Risk Assurance and Policy Group</td>
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<td><strong>(NB: All Procedural Documents which include details of drugs or their management must be approved by the Medicines Management Committee)</strong></td>
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<tr>
<td>Approving Committee/Group (Date)</td>
<td>Patient Safety and Mortality Committee (21/04/2017)</td>
</tr>
<tr>
<td>Name and Title of originator/author:</td>
<td>Dr Mike Mendall, Consultant Gastroenterologist and Trust Lead for Mortality Reviews. Suji Somar, Senior Quality Facilitator - Mortality Reviews</td>
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<tr>
<td>Lead Director</td>
<td>Nnenna Osuji, Medical Director</td>
</tr>
<tr>
<td>Date issued:</td>
<td>May 2017</td>
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<td>Review due date:</td>
<td>May 2020</td>
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<tr>
<td>Target audience:</td>
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<td>Chelsea and Westminster NHS Foundation Trust Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
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<td>Key Words</td>
<td>Level 1 review, Level 2 review, referral to Coroner, outlier alert, mortality</td>
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1 INTRODUCTION

Mortality review is a process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined. It is about attempting to identify those areas where there may be systematic and correctible shortcomings in care that contribute to preventable deaths. The process aims to improve accountability of mortality data, support quality improvement programmes and give assurance to the Board that patients are not dying as a consequence of unsafe clinical practices.

It is likely that all trusts have a proportion of deaths which may be avoidable. Reviewing mortality statistics can give an indication to the levels of quality and safety in the organisation and help identify causes of death in hospital and deaths which may have been avoidable through safer and more efficient delivery of healthcare. It is only by identifying these deaths through a systematic, routine review of mortality that the trust can investigate and find opportunities to support quality improvement programmes and to improve clinical care, systems and processes to eliminate avoidable deaths.

The drive to learn from unintended events is a cornerstone of high performing organisations and safety conscious industries. Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure that patients are safe.

Two significant reports have been published on improving quality and safety in NHS hospitals, the Keogh report into the fourteen Trusts with high mortality ratios and the Berwick report, “A promise to learn – a commitment to act: Improving the safety of patients in England”. The importance of monitoring mortality was reinforced by both reports but their over-riding message was that mortality ratios are just one of the ways Trusts can detect potential quality issues in their organisations and should be treated as ‘smoke detectors’ in a spirit of supportive and genuine inquiry as opposed to definitive conclusions on the quality of care being provided.

In March 2014, the Trust Development Authority mandated that all NHS Trusts begin routinely reviewing all inpatient deaths.

The policy is based on Trust Development Authority (TDA) Mortality Surveillance and Improvement Guidance and 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 Deaths Pub Mar 2017 by the National Quality Board.

2 PURPOSE

This policy ensures that a single, consistent and robust process of retrospective case review is implemented following all in-hospital deaths and that the results of review are securely recorded within the Datix Incident Module for Mortality reviews. The policy recognises the need to ensure that patients are safe and that all deaths are reviewed and learning achieved.

2.1 Scope

This policy applies to all clinicians engaged in the mortality review process under the auspices of the Trust, supported by administrative staff and managers where applicable. Implementation of this policy is to be supported by Directorate management team.

This policy applies to all inpatient deaths occurring in Croydon Health Services NHS Trust including deaths in the Emergency Department. Deaths in hospital of patients under the age of
16 years and maternal deaths are excluded from this process document because these are reviewed under other established Trust processes but learning and outcomes of these reviews are fed through to the Mortality Leads and the Mortality Review Group. Patients 16-18 years of age on adult wards are included in Mortality Reviews. Child deaths are reviewed by the Croydon Child Death Overview Panel (Croydon Health Services and Croydon Commissioning Group), who will share their annual reports with the Mortality Review Group. Maternal Deaths are investigated in accordance with http://intranet.mayday.nhs.uk/Documents/ClinicalGuidelines/Maternal%20Death.pdf

3 DEFINITIONS

**Mortality review** - is a process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined.

**CQC** – Care Quality Commission is the independent regulator of health and social care services in England

**Dr Foster intelligence** – A provider of healthcare variance data and analysis.

**HSMR**- the Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than expected. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong. The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge

**SHMI**- Summary hospital level mortality indicator (SHMI) is the observed number of deaths to the expected number of deaths for a provider and is the main mortality indicator reported nationally and is supported by the Department of Health. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case mix of age, gender, admission method, year index, Charlson Comorbidity index (A calculation of co-morbid complexity) and diagnosis grouping.

**ICD codes** – The International Classification of Diseases (**ICD**), published by the World Health Organisation (**WHO**) is the international standard diagnostic classification for all general epidemiological, health management purposes and clinical use. It is a means of classifying medical terms and is defined as a system of categories to which morbid entries are assigned according to established criteria.

**Mortality outlier alerts** – The CQC use the term ‘outlier’ to describe a service that lies outside the expected range of performance, identified through analysing data that suggests concerning trends in the death rate for specific conditions or operations. CQC uses data generated by the Dr Foster Unit at Imperial College, as well as information from its own Intelligence directorate, to identify alerts.
CUSUM alert - A cumulative sum statistical process control chart plots patients’ actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues.

Hogan Mortality scale - A standard scale to determine whether the death was preventable or not.

4 ACCOUNTABILITIES AND RESPONSIBILITIES

Chief Executive (CEO) - has overall responsibility, on behalf of the Trust Board for ensuring that resources, policies and procedures are in place to ensure the effective reporting, recording, and reviewing of all in-hospital deaths. In practice the (CEO) delegates the day-to-day responsibility of this duty to executive directors and Specialty Leads.

Trust board – has overall responsibility for ensuring the quality and safety of the services, and for creating strong safety cultures that support learning on issues identified through the mortality review process. The Trust Board will receive reports from the Quality and Clinical Governance Committee. Mortality reporting is included at the public section of the Trust Board meeting with the data suitably anonymised.

Medical Director - will assure the board that there is a robust process in place for monitoring mortality rates, the number of deaths reviewed through the mortality process on the standard of care given. The Medical Director will ensure that medical staff is aware of their responsibilities in this process and is also responsible for chairing the Patient Safety and Mortality Committee which provides the strategic oversight to the Mortality Review Group.

Quality and Clinical Governance Committee - has delegated responsibility on behalf of the Trust Board to oversee the management of the mortality review process. The committee will receive a monthly Trust Quality report outlining the previous month’s activity and updates from Dr Foster analysis.

Patient Safety and Mortality Committee - has delegated responsibility from the Quality and Clinical Governance Committee to promote the culture of transparency and learning and to provide assurance to the Trust Board via the Quality and Clinical Governance Committee on all patient safety and mortality issues. It is chaired by the Medical Director and provides the Strategic oversight to the Mortality review Group.

Mortality Review Group - provides assurance to the Patient Safety & Mortality Committee that all deaths are subject to a mortality review by the development of a culture and practice of standard clinical audit of mortality. It identifies areas of concern relating to clinical practice in instances where patients died and to ensure that these are escalated to the relevant clinical leaders and is chaired by the Trust Lead for Mortality Reviews. Terms of reference as per Appendix C

Trust lead for mortality – has operational responsibility for ensuring that mortality reviews are undertaken for all deaths and that in depth reviews are conducted for mortality outlier alerts and on any flags identified on Dr Foster. Chairs the Trust Mortality Review Group meetings ensuring that there is appropriate attendance from professional groups and escalating issues to the Patient Safety and Mortality Committee. Liaise with the clinical directorate leads to ensure that directorate mortality review processes and actions are being undertaken.
Where issues of clinical competence are apparent escalate concerns to the relevant clinical directors.
Oversee responses to mortality outlier alerts. Monitor Dr Foster data for HSMR- Hospital standard mortality ratio and SHMI- Summary hospital level mortality indicator

**Senior Quality Facilitator** - will provide administrative support to the Mortality review group maintaining records of attendance at mortality review group meetings.
Prepare and circulate papers for Patient safety and mortality committee
Prepare and circulate agenda and minutes for the Mortality Review Group
Co-ordinate with clinical teams to conduct level 2 reviews of mortality outlier alerts using in depth review template.
Cross compare Datix mortality module with Informatics data to ensure all in-hospital deaths are registered on Datix to enable to mortality reviews to be undertaken.
Screening finalised reviews and give final approval- screen for issues which have not been raised through the incident reporting and serious incident reporting process.
Escalate potential serious incidents.

**Directorate Clinical Leads** - will ensure that the policy is implemented throughout the specialities within the divisions.
Ensure that in depth reviews are completed by a multi-disciplinary team and that clinicians are kept informed of outcomes of their work from findings of mortality reviews and clinical governance sessions. Action logs of findings from reviews which are presented to clinical governance are maintained and monitored.

**Directorate triumvirate** - will ensure that findings from mortality reviews are reported and discussed as part of the directorate governance process, to demonstrate compliance with CQC outcome 16.
Maintain a log of learning points and actions as part of their directorate level 2 review processes.
Provide regular update to the Mortality review group on progress of actions identified through Mortality reviews.

**Consultants** - are responsible for reviewing deaths in accordance with this policy. Responsible for ensuring that any deficiencies in care /systems or processes are identified through the review process and are shared and escalated through the divisional structures to facilitate wider organisational learning and that junior doctors routinely participate in mortality review meetings.
Understand the outcomes of their clinical practice and must be aware of their mortality data.
Ensure that junior doctors are aware that deaths need to be reported on DATIX within 24 hours for deaths occurring during the week and 72 hours for deaths at the weekend and that information provided on death certificates is accurate in particular that the cause of death is recorded rather than 'mode of dying' e.g. heart failure and document underlying cause in sequence

**Clinical staff** - are responsible for contributing to multidisciplinary meetings where deaths are reviewed.

**Directorate governance leads** – will ensure that findings from mortality reviews are reported and discussed as part of the directorate governance process.
Provide regular update to the Mortality review group on progress of actions identified through Mortality reviews

**Head of patient safety** - will make the necessary escalations through the SI process when informed of potential incidents
**Hospital Registry** - will support the implementation of this policy by informing doctors of their responsibility to register deaths on Datix at the time of completing other mandatory reports.

**DATIX manager** - will provide training in respect of reporting deaths on the Datix reporting system.
Support provision of bespoke reports for the Mortality Review Group and directorate clinical governance sessions

**Health Informatics department** - will provide a weekly report of all deaths from the previous week.
Provide ad hoc reports from Dr Foster.

**Head of Communications** - is responsible for handling media enquiries, and reporting incidents that may attract media interest to the CCG. Where it is necessary to provide information to large numbers of patients, stakeholders or members of the public a telephone helpline will be established in line with the Trusts "Major Incident plan" available on the Trust intranet

### 5 PROCEDURE/COURSE OF ACTION REQUIRED

All inpatient deaths are subject to a retrospective mortality review by the development of a culture and practice of standard clinical audit of mortality. The CQUIN in 2015-16 set targets that 85% of deaths should have a Level 1 review and 100% of deaths requiring a Level 2 review should be completed. Having completed the CQUIN, the Trust continues with these as targets.

Registering a death on the Datix mortality review reporting form is the responsibility of the junior doctors and is completed for all deaths in the registry office at the time of completion of the death certificate or referral to the coroner. This must be within 24 hours for deaths occurring during the week and 72 hours for deaths at the weekend. This registration triggers a notification to the consultant in charge of the care of the patient.

#### 5.1 Level 1 Mortality Review

As detailed in [Appendix D](#), following the on line registration of death on Datix the consultant/speciality consultants will receive an email notification. The level one review involves the consultant responsible for the care of the patient or a nominated consultant in that speciality confirming the cause of death answering the following questions leading to the conclusion that the death either does or does not require an in depth review (Level 2 review).

1. Was the death avoidable? (Hogan preventability score 1- definitely not preventable, 2- Slightly preventable, 3- Possible preventable less than 50/50, but close call, 4 – Probably preventable more than 50/50, but close call, 5- Strong evidence of preventability, 6- Definitely preventable)

2. Please evaluate standard of care (1- No suboptimal care, 2- Sub optimal care but would not have affected outcome, 3- Suboptimal care might have affected outcome, 4 – Suboptimal care, expected to have affected outcome)

A two-tier system is in place whereby the Level 1 review allocates Hogan and Standard of care scores; if both of these are 1, then no further review is required; if either of these is ≥2, then an in-depth Level 2 review is required. The level 2 form will automatically pop up if Hogan score ≥ 2 OR standard of care score ≥ 2.

All Level 1 reviews with Hogan and Standard of Care score ≥3 are automatically escalated as incidents to the Executive Management Team for consideration to manage and declare the
incident as Serious Incident. If the case is declared as an SI, then it follows the SI management process and investigation process.

5.2 Level 2 Mortality Review (in-depth review)

Level 2 review (Appendix E) is an in-depth review which is conducted using the Structured Judgement methodology on all cases where Hogan score ≥ 2 OR standard of care score ≥ 2. Clinicians are expected to record explicit judgment about the quality of care and rate the care received on a scale of 1 to 5 (1- very poor care, 2- poor care, 3- adequate care, 4- good care, 5- excellent care) on the following phases of care that the patient has received and whether it was in accordance with current good practice.

1. Admission and initial management (Approximately the first 24 hours)
2. On-going Care
3. Care during a Procedure (if applicable)
4. Peri-operative Care (if applicable)
5. End of Life Care

A level 2 mortality review must occur preferably at Speciality Level Mortality and Morbidity meetings or at monthly clinical governance. A level 2 mortality review must be objective and multi-disciplinary. It must involve at least one consultant who was not involved in the care of the patient. Where relevant, other specialities and disciplines should be invited.

A record of the review must be entered onto the Datix and minutes of the mortality review meeting retained as evidence and available to the corporate compliance team.

Actions from Level 2 mortality reviews must be recorded on Datix and onto directorate held and maintained action logs and disseminated through governance channels.

A level 2 review is required on –

- All deaths where family, carers or staff have raised a formal complaint about the quality of care provision.
- All deaths of Learning disability patients.
- All deaths of mentally disabled patients.
- All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator.
- Cases referred to Inquests and issue of a ‘Regulation 28 report on Action to prevent future Deaths’ in order to examine the effectiveness of the review process.

Some deaths may warrant additional investigation and should be guided by the circumstances for investigation as per the Serious Incident Framework.

5.3 Reporting to HM Coroners

A death should be reported to the Coroner if the cause of death is unknown on the South London Coroner electronic referral form. The electronic referral form and notes for reporting doctors is detailed in Appendix F.
5.4 CQC Mortality Outlier Alerts

The CQC use the term ‘outlier’ to describe a service that lies outside the expected range of performance, identified through analysing data that suggests concerning trends in the death rate for specific conditions or operations. CQC uses data generated by the Dr Foster Unit at Imperial College, as well as information from its own Intelligence directorate, to identify alerts. All of the outliers are calculated using patient-level data from hospitals which become part of a national system called hospital episode statistics (HES).

A Level 2 case note review is conducted to review all the deaths identified in the outlier alert and reported in accordance with example response from CQC on Appendix G.

5.5 Duty of Candour

Ensure patients, relatives or carers are informed where necessary of when things have gone wrong or have not had the desired outcome in line with the Trust policy ‘Duty of candour’ available on the Trust intranet and liaison with the Trust Family Liaison and Investigation Facilitator.

5.6 Reporting Requirements to Committees

The following sets out the minimum required information for committees –

Trust Board will receive quarterly report on the previous quarter for the following

- Number of in-patient deaths
- Breakdown of cases requiring in-depth review by preventability of death and any actions planned or undertaken for the same
- Dr Foster report on HSMR trends, Weekend/ Weekday Mortality, Palliative care coding, CUSUM alerts, Patient Safety Indicators relating to Mortality – Deaths in low risk diagnosis group and deaths after Surgery
- Actions and lessons learned following Mortality reviews of deaths identified as preventable

The quarterly report to the Trust Board will be in accordance with the Learning from Deaths dashboard provided by the Department of Health.

Mortality review Group will receive the following reports monthly

- Number of in-patient deaths and progress update on the number of mortality reviews undertaken
- Random 10% of cases finalised the previous month to audit for Quality Assurance
- Random listing of cases to audit by specialty/ consultant
- Listing of cases identified as requiring Level 2 in-depth review for scrutiny
- Dr Foster report on HSMR trends, Weekend/ Weekday Mortality, Palliative care coding, CUSUM alerts, Patient Safety Indicators relating to Mortality – Deaths in low risk diagnosis group and deaths after Surgery
- Learning points and action log from Level 2 reviews

Patient Safety and Mortality Committee will receive the following reports monthly

- Number of in-patient deaths and progress update on the number of mortality reviews undertaken
- Breakdown of cases requiring in-depth review by preventability of death.
- Dr Foster report on HSMR trends, Weekend/ Weekday Mortality, Palliative care coding, CUSUM alerts, Patient Safety Indicators relating to Mortality – Deaths in low risk diagnosis group and deaths after Surgery
- Report and action plan following in-depth review of flags on Dr Foster (if required)
• Reports on CQC Mortality outlier alerts (if required)
• Actions arising from Level 2 Mortality reviews for the previous month

Directorate Quality Boards will receive the following reports monthly
• Update on the number of reviews completed and data on outstanding reviews
• Action points identified through reviews for an update on actions required, Lead, and
timescales for completion.

Clinical Governance
• List of Level 2 cases for finalising and dissemination of learning points.

Annual Quality Account
• Evidence of learning and action as a result of mortality reviews.

5.7 Dissemination of Learning points following Mortality reviews

Learning is channelled through the Patient Safety and Mortality Committee and utilises three key messages as a vehicle for weekly dissemination of learning. Collaborative working with a shared learning LIA group is also utilised for dissemination of learning from serious incidents, complaints, compliments and mortality reviews. Learning points are also discussed at Directorate Clinical Governance Meetings.

6 TRAINING

A comprehensive guidance (Appendix H) is available for doctors on the Mortality review page of the intranet. Guidance is also provided by the Specialty Leads on an adhoc basis and at Clinical Governance. Junior doctors and hospital consultants will receive training to use Datix.

Structured Judgement Methodology Training on Mortality reviews will be made available to staff by the Royal College of Physicians.

6.1 Equality Impact Assessment

The Equality Impact Assessment for this policy is attached in Appendix A.

7 MONITORING COMPLIANCE

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<td>Report cross comparing Datix mortality module with Informatics data</td>
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8 REFERENCES

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 Deaths Pub Mar 2017 by the National Quality Board

Trust Development Authority (TDA) Mortality Surveillance and Improvement Guidance

CQC - Learning, Candour and Accountability, A review of the way NHS trusts review and investigate the deaths of patients in England

9 ASSOCIATED DOCUMENTATION

This Policy should be read in accordance with the following Trust policies, procedures and guidance:

Incident Management and Investigation policy
Duty of Candour policy
Deteriorating Adult policy

10 VERSION HISTORY TABLE

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<td>Suji Somar</td>
<td>Risk Assurance and Policy Group</td>
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APPENDIX A – EQUALITY IMPACT ASSESSMENT

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

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Policy: Policy on Mortality Review Process  Date: 03/04/2017

Officer conducting this Analysis: Suji Somar, Senior Quality Facilitator Mortality Review

Child deaths are excluded from this policy as this is reviewed by the Croydon Child Death Overview Panel.
## APPENDIX B – CONSULTATION TEMPLATE

1. **Procedural Document’s Name:** Policy on Mortality review Process

2. **Procedural Document Author:** Dr Mike Mendall and Suji Somar

3. **Group/Committee Consulted** | **Date**
--- | ---
Mortality Review Group | 11/04/2017
Patient Safety and Mortality Committee | 21/04/2017

4. **Name and Title of Key Individuals Consulted** | **Date**
--- | ---
Dr Nnenna Osuji, Medical Director and Consultant Haematologist | 05/04/2017
Dr Mike Mendall, Consultant Gastroenterologist and Trust Lead for Mortality reviews | 05/04/2017
Dr Joseph Rehman, Consultant Geriatrician and Deputy Trust Lead for Mortality reviews | 05/04/2017
Mr Rhys Thomas, Consultant General and Upper GI Surgeon | 05/04/2017
Dr Ashok Iyer, AMU Consultant | 05/04/2017
Dr Jakkala Saibaba Ravi, Consultant Anaesthetist and ITU M&M Chair | 05/04/2017
Dr Sarah Horne, ED Consultant | 05/04/2017
Janet Coninx, Head of Patient Safety | 05/04/2017
Heather Sud and Jane Gorman, Head of Patient Safety, Nursing | 05/04/2017
Sarah Vernon, Operational Clinical Lead - Acute Therapies | 05/04/2017

5. **Comments received**
APPENDIX C – TERMS OF REFERENCE OF THE MORTALITY REVIEW GROUP

Mortality & Morbidity review Group

Terms of Reference

Background
Mortality meetings are a core component of any quality plan focusing on systems and processes used in the service and may generate information on the performance of individual practitioners.

Purpose
The purpose of the group is to provide assurance to the Patient Safety & Mortality Committee that all deaths are subject to a mortality review by the development of a culture and practice of standard clinical audit of mortality.

To identify areas of concern relating to clinical and organisational practice in instances where patients died and to ensure that these are escalated to the relevant clinical leaders and/or under the Trust Incident Management and Investigation policy, as appropriate.

To investigate any conditions or procedures identified as outlier on Dr Foster. To contribute to improving the quality and accuracy of clinical coding from hospital episodes resulting in death by feeding back to the Coding department.

To identify trends in mortality and ensuring that these are communicated throughout the organisation.

The meeting is not a forum to discuss individual’s competence but where competence issues are apparent, the chair should consider escalating the matter to the appropriate clinical leaders.

Objectives
The meeting is aimed at quality assurance, quality improvement and learning from the mortality review process.

Accountability and Reporting Arrangements
The group is established as a permanent sub-group of the Patient Safety and Mortality Committee under the leadership of the Medical Director, and is therefore accountable to this committee and will submit a monthly report. The group recognises and maintains oversight over specialist reviews conducted in obstetrics and paediatrics.

Membership
All members will be expected to engage fully with the agenda and make full and positive contributions as appropriate. Group members are expected to attend all meetings but, as a minimum, at least two thirds of the meetings in each financial year or send a nominated deputy who can make decisions on their behalf. Details of attendance will be reviewed by the group on an annual basis. The group will have the power to co-opt additional members, subject to
approval by the Chairman. The group will ensure that all levels of the multidisciplinary team are involved in the critical analysis of systems and processes leading to an outcome of care.

The group is chaired by a hospital consultant, the Trust Mortality Lead (Chair); the other members are:

- a clinical deputy chair
- a general physician
- an elderly care physician
- a surgeon
- An Intensive Care Unit clinician
- An Emergency Department clinician
- Head of Patient Safety for Nursing
- Clinical Lead from Allied Health Professional
- Clinical Lead from Nursing
- Clinical coding
- Palliative Care
- Pharmacy
- Mortality Reviewer (providing administrative support for the group)
- Directorate Governance Leads
- Other individual clinicians invited to monthly meetings.

**Quorum:**

Two doctors plus at least one allied healthcare professional, one pharmacist and one nurse.

If the nominated leads are unable to attend, deputies may attend in their absence and the attendance of deputies will count towards establishing a quorum.

**Conflicts of interest:** When members believe they have a conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the groups’ functions they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

**Frequency of meetings:**

Meeting to be held monthly.

**Authority:**

The group is authorised to
monitor and ensure quality of the mortality review process across the Trust;
identify cases for each directorate to review;
seek out and secure any information it requires from any employee and all employees are directed to cooperate with any request made by the group.

Monitoring Effectiveness:

- The group will review its accountabilities and responsibilities annually.
- The group will complete an annual self-assessment of the effectiveness of the committee.
- The group will monitor the number of avoidable deaths of all levels of severity quarterly.

Key indicators:
- CQC Regulation16
- The TDA’s “Mortality Surveillance and Improvement Guidance”.

Key Tasks:
- Develop a coordinated sustainable process for review of Mortality within the trust.
- Report trends and themes to Patient Safety and Mortality Committee.
- Pro-active review by means of audit and reporting on mortality outliers.
- Review of Dr Foster data.
- Monitor directorates’ mortality reviews and action plans and provide cases for discussion at each month’s clinical governance
- Escalation of concerns such as potential serious incidents.

Reporting requirements:
The mortality review group is required to keep minutes of all meetings that outline the issues discussed and include a clear record of any decisions or recommendations made.

Review of Terms of Reference:
Terms of reference will be reviewed annually and will be sent to Patient Safety and Mortality Committee for approval.

Sub-group:
None.

Uploading to the Intranet:
The terms of reference and meeting papers will be saved on the Compliance and regulation Team’s shared drive.
APPENDIX D – PROCESS FLOW CHART FOR MORTALITY REVIEWS

Junior Doctor /bereavement team completes the death certification process and completes Mortality form on Datix

Automated email sent to the allocated consultant

Consultant reviews the information entered by the Junior Dr and completes the Level 1 Mortality Review on Datix assigning Hogan and Standards of care score

If the initial Hogan or Standard of care Score < 2, send the form for final approval
If Hogan or Standard of care Score ≥ 2, Level 2 review is required

Complete the Level 2 review on Datix as draft (save as being reviewed on Datix) and discuss the case at clinical governance or specialty level meetings where two or more clinicians are present to reconfirm findings.

Send the Datix for final approval or if completing the paper form send it to Patient Safety and Risk Team

Please note all reviews with Hogan and Standard of Care score ≥3 are automatically escalated as incidents to the Executive Management Team for consideration to manage and declare the incident as SI.
### APPENDIX E - LEVEL 2 MORTALITY REVIEW

<table>
<thead>
<tr>
<th>Name of reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Patient identifier, M000 number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DATIX number</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Age of patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Does this patient have a Learning Disability?</th>
</tr>
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<td></td>
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</tbody>
</table>

On reviewing the case, in your opinion, comment on the care received during the following phases of care and whether it was in accordance with current good practice. Please include any other information you think is important or relevant.

<table>
<thead>
<tr>
<th>Admission and Initial care (first 24hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating very poor 1 2 3 4 5 excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>On-going care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating very poor 1 2 3 4 5 excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care during a procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating very poor 1 2 3 4 5 excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perioperative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating very poor 1 2 3 4 5 excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>End of Life care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating very poor 1 2 3 4 5 excellent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DNACPR order? YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Was resuscitation performed? YES/NO</th>
</tr>
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<tbody>
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</tbody>
</table>

Please state time to first consultant review following admission:

Please detail all operative interventions:

Please detail admissions to ITU or review by CCOT:
### Hogan mortality score

1. Definitely not preventable  
2. Slight evidence for preventability  
3. Possibly preventable but not very likely, less than 50-50 but close call  
4. Probably preventable, more than 50-50 but close call.  
5. Strong evidence of preventability  
6. Definitely preventable

Please evaluate the **standard of care** received:

1. No suboptimal care  
2. Suboptimal care but would not have affected outcome  
3. Suboptimal care, might have affected outcome*  
4. Suboptimal care, would reasonably be expected to have affected outcome*

**Coding:** Please comment accuracy of coding:

- Cerner codes  
- Dr Foster codes for primary condition  
- Co-morbidities

If standard of care has been classified as 3 or 4 please provide further details:

Has the patient been receiving community care prior to admission:

Names of any care home or nursing home the patient was admitted from:

Do you feel that it would have been more appropriate for the patient to remain in the care home rather than being admitted to hospital, or to have been admitted earlier?

### Learning points, presentation of findings and actions

<table>
<thead>
<tr>
<th>Learning point/ Issue</th>
<th>Action to be taken (e.g. report as incident; refer to the coroner; discuss learning at Clinical Governance etc.)</th>
<th>Person responsible</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
APPENDIX F - SOUTH LONDON CORONERS REFERRAL FORM

South London Coroner (Croydon, Bromley, Bexley and Sutton)

REPORT OF DEATH

Please complete ALL questions on this form, save the form and send it to the coroner’s office by email to southlondoncoroner@croydon.gcsx.gov.uk
CC: mhn-tr.RiskManageatCHS@nhs.net

Coroner’s officers deal with referrals between 8 a.m. and 11.45 a.m. Monday to Friday (excluding Bank Holidays). Deaths should be reported immediately if the death occurs during these hours. Deaths occurring outside these hours may be referred at any time before 8 a.m. on the next working day. Delays in making referrals can cause significant distress and inconvenience for families, and can lead to difficulties in securing evidence. **Serious adverse incidents leading to admission or during admission should be notified urgently**

In the case of the death of any person attended in his last illness by a registered medical practitioner, that practitioner is obliged to sign and transmit to the registrar a certificate stating to the best of his/her knowledge and belief (and on the balance of probability) the cause of death (*Births and Deaths Registration Act 1953 s.22(1)*). The consultant in charge of the care of the deceased is ultimately responsible for completion of the MCCD, and should be consulted if the death is to be referred by another member of the team.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting Doctor</strong></td>
<td></td>
</tr>
<tr>
<td>Reported by (name and grade)</td>
<td></td>
</tr>
<tr>
<td>Place of work/hospital/department</td>
<td></td>
</tr>
<tr>
<td>Mobile number</td>
<td></td>
</tr>
<tr>
<td>Bleep Number</td>
<td></td>
</tr>
<tr>
<td>Email address</td>
<td></td>
</tr>
<tr>
<td>Alternative contact if appropriate</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for referral</strong>&lt;br&gt;(see notes overleaf)</td>
<td></td>
</tr>
<tr>
<td><strong>Deceased</strong></td>
<td></td>
</tr>
<tr>
<td>Full name</td>
<td></td>
</tr>
<tr>
<td>Home address</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Hospital number (if any)</td>
<td></td>
</tr>
<tr>
<td>Name of treating consultant</td>
<td></td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td></td>
</tr>
<tr>
<td>Healthcare professional who pronounced life extinct</td>
<td></td>
</tr>
<tr>
<td>Date of death and time if known</td>
<td></td>
</tr>
<tr>
<td>Place of death</td>
<td></td>
</tr>
<tr>
<td>Current location of body</td>
<td></td>
</tr>
<tr>
<td>GP details</td>
<td></td>
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<tr>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Phone number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next of kin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name(s)</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone numbers</td>
</tr>
<tr>
<td>Relationship to deceased</td>
</tr>
<tr>
<td>Whether next of kin informed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circumstances of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief circumstances of death</td>
</tr>
<tr>
<td>Medical and medication history (if known)</td>
</tr>
<tr>
<td>Particular family concerns</td>
</tr>
<tr>
<td>Whether reported to police</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent medical cause of death (if known)</td>
</tr>
<tr>
<td>1a</td>
</tr>
<tr>
<td>1b</td>
</tr>
<tr>
<td>1c</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>Are you able to issue an MCCD?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any incident or concern about medical or other care provided (relevant to the death)</td>
</tr>
<tr>
<td>Was the deceased subject to a DOLS?</td>
</tr>
<tr>
<td>Is a pacemaker in place, if so please indicate make if known</td>
</tr>
</tbody>
</table>

Coroner’s office phone number: 020 8313 1883

**NOTES FOR REPORTING DOCTOR**

1. Possible reasons for referral to the coroner are as follows

   - □ the cause of death is unknown
   - □ the deceased was not seen by the certifying doctor *either* after death *or*
   - □ within 14 days before death
   - □ the death was violent or suspicious
   - □ the death was unnatural
   - □ the death may be due to an accident (whenever it occurred)
☐ The death may have occurred as a result of poisoning, the use of a controlled drug, medicinal product or toxic chemical
☐ the death may be due to self-neglect or neglect by others
☐ the death may have been caused or contributed to by any treatment or procedure of a medical or similar nature, or by a lack of treatment, or due to medical mishap or negligence
☐ the death may be due to an industrial disease or related to the deceased’s employment
☐ the death may be due to an abortion
☐ the death occurred during an operation or before recovery from the effects of an anaesthetic
☐ the death may be a suicide
☐ the death occurred during or shortly after detention in police or prison custody
☐ the death occurred while the deceased was subject to compulsory detention under the Mental Health Act or a Deprivation of Liberty Safeguards authorisation (DoLS)
☐ for any other specified concerning feature

2. The list is not exhaustive, and borderline or doubtful cases should be referred for discussion.

3. Deaths due to the long term effects of alcohol and smoking are not regarded as unnatural.

4. It is no longer necessary to refer deaths that occur solely because the death occurred within 24 hours of arrival at hospital.

5. It is usually prudent to refer deaths that occur within two weeks of an operation or comparable clinical procedure and where there is any allegation of medical mismanagement or alleged negligence.

6. A referral by a hospital doctor must be reported or closely supervised by a senior doctor.

7. If the referral is accepted the coroner’s officer will inform the bereavement office. If queries arise the coroner (by a coroner’s officer) may wish to contact you.

8. Once a death is referred to the coroner, the reporting doctor may not issue an MCCD to a family until agreed by or on behalf of the coroner.

9. Where the medical cause of death is agreed by the coroner, the doctor signing the MCCD must indicate that the coroner has been informed and must record the exact words as agreed with the coroner (with no abbreviations)
APPENDIX G - EXAMPLE RESPONSE TO CQC FOLLOWING RECEIPT OF AN OUTLIER ALERT

Please note that this example is intended to illustrate the type of response and level of detail we are looking for from a trust. However, we would like to emphasise that this is just an example and we acknowledge that you may have a different approach.

XXXXXX HOSPITAL NHS TRUST

Review of mortality outlier alert for ‘peripheral and visceral atherosclerosis’

REPORT OUTLINE

Response to Care Quality Commission (CQC) following notification from the Dr Foster Unit at Imperial College of a mortality outlier alert for ‘peripheral and visceral atherosclerosis’.

Action taken:

A comprehensive retrospective notes review, including paper and IT records was undertaken.

Method:

Patients were identified for review on the basis that they had been admitted with a primary diagnosis of ‘peripheral and visceral atherosclerosis’ (ICD -10 diagnosis codes I70, I73.9, K55) and died between XX/XX/XX and XX/XX/XX. A list of 36 cases was identified and 33 cases are reflected in this analysis. In 3 cases there were gaps in the available data and they were excluded, however these notes will be retrieved and reviewed at a later date.

A data collection tool was agreed. The review tool includes information on demographics, details on admission pathway, timings of medical reviews and interventions. It also includes an NCEPOD and Hogan score. This is the tool that we have agreed to utilise as part of the Trust Mortality Review Panel process when we review all in-hospital deaths. In addition, the tool is also used across the XXXXXXX Region (agreed by the Regional Mortality Group) so that we can produce peer to peer comparisons and challenge.

The review team consisted of the following:

Mr XXXXXX - Consultant Vascular Surgeon & Clinical Lead - Clinical review and assimilation of audit report
Mr XXXXXX - Consultant Vascular Surgeon - Clinical review
Mr XXXXXX - Consultant Vascular Surgeon - Clinical review
Mr XXXXXX - Clinical Governance Manager - co-ordination of the review process

Patient summaries are included on pages XX of this report, and the review tool on pages XY.

Results:

- The median age was 80 (mean 78, range 52-93).
- 8 lived at home and received minimal or no social care; 19 lived at home with maximal support; 6 resided in institutional care.
- There were 19 Female patients and 14 Male patients.
- The median length of stay was 3 days (mean 8.8, range 1-67).
There was no correlation with day of admission or date of death. Weekend admissions represented cases and weekend deaths represented cases.

28 cases were admitted via the Emergency Department.

24 cases were admitted between the hours of 0700 and 2200 (to represent “in-hours” reflecting typical on-site senior cover) and 9 were admitted in the remaining 9 hours.

The initial clinical assessment was undertaken by the following grades:

- Nurse Practitioner – 2, Foundation grade - 12; SHO grades -5; Registrar grades - 12; Consultants -2.
- The average time to first Consultant review was 6.7 hours. In 2 cases there was a wait of more than 12 hrs. In 6 cases the timing of review was unclear due to poor documentation.
- 31 of the 33 cases had a DNACPR form complete at the time of death and there was evidence of end of life interventions at the time of death.
- 11 patients had an operative intervention during their last hospital admission.
- There were 4 admissions to Intensive Care.
- Appropriate NEWS in 100% of cases was observed.
- Significant and appropriate input of Critical Care Outreach and Intensive Care was evident.
- All but one patient had a Hogan score of 1. That was a patient who had a fall whilst on a vascular ward with an ischaemic leg resulting in a hip fracture. He had a prolonged hospital stay and subsequently had a cardiac arrest secondary to a myocardial infarction. (Case 21).
- The average NCEPOD score was 1.27. There was 1 case attributed a score of 2 – the patient described above who had a fall leading to a hip fracture.
- There were 4 cases attributed a score of 3 – due to poor documentation in the medical notes (Organisational factor).
- For 5 of the 6 patients who resided in institutional care, it was felt that they would have been better managed in the nursing home rather than admitted to hospital.

**Names of care homes and nursing homes:**

The six patients who resided in a care or nursing home were admitted from the following homes:

**Case 1**  
XXXXXX Care Home, XXXXXX, XXX XXX

**Case 5**  
XXXXXX Nursing Home, XXXXXX, XXX XXX

**Case 17**  
XXXXXX Care Home, XXXXXX, XXX XXX

**Case 18**  
XXXXXX Care Centre, XXXXXX, XXX XXX

Case 18 – although it is recorded that the patient was in a “residential home”, the home did have nursing care facilities. However she had a relatively short history and it was appropriate that she was seen in a hospital setting. However once a clinical decision had been made she
could, in theory, have been managed in the nursing home. The other 5 patients would all have been better managed in their nursing home in the reviewer’s opinion.

Summary:

- This analysis reveals a cohort of elderly and dependent patients.
- 27% of patients were admitted between the hours of 2200 and 0700.
- 85% of patients presented to the Emergency Department.
- We can be reassured that there were no preventable deaths.
- We can be reassured that there is no apparent correlation between death and either the day of admission or the day of death.
- There are numerous examples of excellent care and this is particularly evident in the communication with families and is evidenced by resuscitation discussions and implementation of end-of-life care.
- Physiological monitoring is described and complete and there is evidence that escalation was being considered and discussed.

Conclusions:

The majority of these patients presented to Accident and Emergency with a terminal non-salvageable condition. Several patients had community DNACPR forms in place and might have been more appropriately managed in the community with forward planning. Death Certification accuracy could be improved.

A number of patients presenting in a moribund state have been recorded as having mesenteric ischaemia as a default diagnosis when they have had symptoms of abdominal pain and are clearly terminal.

Areas identified for Improvement:

- Improvements around clinical documentation
- Accuracy of death certification
- Clinical coding of significant vascular events

Action Plan:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
<th>Lead</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing the review findings</td>
<td>Presentation of outcomes internally, i.e. General Surgery Clinical Governance meeting, Trust Clinical Governance Steering Group and the Mortality Review Group Presentation externally to XXXXXX CCG via the Quality Review Group</td>
<td>Lead Reviewer / Medical Director / Clinical Governance Manager</td>
<td>XXX 20XX</td>
</tr>
<tr>
<td>Evidence of poor documentation</td>
<td>Raise awareness and use specific examples at local Clinical Governance Group Highlight examples at Clinical Governance Leads meeting</td>
<td>Review Team</td>
<td>XXX 20XX</td>
</tr>
</tbody>
</table>
Detailed findings of case note review

Case 1
82yr old female nursing home resident with advanced dementia admitted XX/XX/XX at 1150 in a moribund condition with an ischaemic leg. Admitted directly to A&E. Not previously known to the vascular team. Seen by the Consultant Vascular Surgeon on call within 10 minutes of arrival. Not salvageable. Treated palliatively. DNACPR form completed. Patient died within 48 hours. Death discussed with coroner “Fragility of old age” recorded on death certificate.
Hogan score: 1
NCEPOD score: 1

Case 2
77 yr old severely demented female admitted under general surgery at 1730 on XX/XX/XX with a 4 day history of constipation and abdominal distension. She lived at home with her husband with carers 4 times a day and was dependent for all activities of daily living. She was admitted via the A&E Department. She died within a few hours of admission. A DNACPR form was in place. The death certificate records “Bowel ischaemia” as the cause of death and Alzheimer’s disease as a significant contributing condition.
Hogan score: 1
NCEPOD score: 3

Case 3
84yr old female with community DNACPR in place. Lived in her own home but known to the Community Mental Health Team with some cognitive impairment. Transferred from another hospital with an ischaemic leg. It was not clear as to how long the leg had been ischaemic. The patient was unable to give a meaningful history. Arrived on XX/XX/XX at 1750. Seen by Vascular Consultant within 2 hours. Had a right common femoral endarterectomy and iliac embolectomy performed urgently which was unsuccessful in salvaging the leg. Patient declined amputation. After discussion with family, it was decided to palliate the patient and she died on XX/XX/XX, 15 days after admission. The death certificate recorded the cause of death as Ischaemic right leg due to peripheral vascular disease.
Hogan score: 1
NCEPOD score: 1
# APPENDIX H- COMPREHENSIVE GUIDANCE FOR MORTALITY REVIEW PROCESS

**Patient dies.**

**Junior doctor/bereavement team**

As part of the death registration process junior doctor enters the death in Datix.

**Process:** Open Datix from Intranet
- Add new incident
- ‘Click here to complete a Mortality report’ link
- Opens: Mortality review reporting form

**Submit**

- Within: 3 days

<table>
<thead>
<tr>
<th>Form status: ‘In the holding area awaiting review’</th>
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</thead>
</table>

**Mortality registration is complete**

**Automated email sent to the allocated Consultant**

**Consultant**

Process: Consultant - use the link in automated email to access the record on Datix and:
- Fill in time of incident (you can put 00:00 for ease)
- Fill in ‘Description’ and ‘Action taken fields’ – these are mandatory fields which cannot be pre-filled, but are not required for this process - you can put full stops or ‘x’ for ease.
- Review the information entered by the junior doctor for completeness and accuracy
- Fill in additional information:
  - Hogan score
  - Standard of care score
  - Any comments
  - Any actions
- At the bottom of the form, change status to: ‘Awaiting final approval’

<table>
<thead>
<tr>
<th>Form status: ‘Awaiting final approval’</th>
</tr>
</thead>
</table>

**Level 1 review is complete**

**Level 1 approval Senior Quality Facilitator**

Checks all the Level 1 reviews:
- if Hogan score ≤2 AND standard of care score ≤2, then change status to ‘Finally approved’ – no further action is required.

<table>
<thead>
<tr>
<th>Form status: ‘Finally approved’</th>
</tr>
</thead>
</table>

**Level 2 Review Consultant**

if Hogan score ≥2 OR standard of care score ≥2, then a Level 2 (in-depth) review is required. The level 2 form will automatically pop up if Hogan score ≥2 OR standard of care score ≥2. Complete the level2 review.

<table>
<thead>
<tr>
<th>Form Status : Awaiting Final Approval</th>
</tr>
</thead>
</table>

**Senior Quality Facilitator**

- if Hogan score ≥3 OR standard of care score ≥3, then the death should be reported on Datix as an incident (if an incident report is already on Datix, comment should be added to note the Mortality review scores and any concerns raised) and escalated to the Head of Risk and Patient Safety.
<table>
<thead>
<tr>
<th>Consultant Specialty Mortality Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant presents the case for discussion at the departmental Mortality &amp; Morbidity or Clinical Governance meeting, where any variation in answers to the questions to the Level 2 form are to be agreed. Any learning and actions are recorded on the Level 2 section of the Datix form. The Specialty Mortality Lead ensures that the above process is followed, that all Level 2 reviews are completed on Datix.</td>
</tr>
</tbody>
</table>