## Document Control

### Title

**Standard Operating Procedure for the Mortality Peer Review process**

### Author

**Author’s job title**

Head of Corporate Governance

**Directorate**

Strategy & Transformation

**Department**

Corporate Governance

### Version Control

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### Document Class

Standard Operating Procedure

### Target Audience

Medical Staff
Senior Nursing Staff
Clinical Coding Team
Clinical Audit Department
Performance Team
Governance Team
Quality Improvement Team

### Distribution List

Medical Staff
Senior Nursing Staff
Clinical Coding Team
Clinical Audit Department
Performance Team
Governance Team
Quality Improvement Team

### Distribution Method

Trust’s internal website

### Superseded Documents

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17.01.2017

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01.01.2019

### Review Cycle

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1. **Background**

1.1. Concern about patient safety and scrutiny of mortality rates has intensified recently with high-profile investigations into NHS hospital failures combined with the Dr Foster report and patient safety rating for NHS Trusts. There is an increased drive for Trust Boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

1.2. Effective clinical audit and peer review processes incorporating analysis of mortality and morbidity contribute to improved patient safety. The specialty M&M meetings, established to review deaths as part of professional learning, also have the potential to help provide assurance that patients are not dying as a consequence of unsafe clinical practices.

1.3. Concentrating attention on the factors that cause deaths will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient.

1.4. Retrospective case note reviews help to identify examples where processes can be improved and gain an understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care.

1.5. A formalised process will also address the Care Quality Commission’s publication in December 2016 of a review into the way NHS Trusts review and investigate the deaths of patients, ‘Learning, candour and accountability’ which builds on the need to maximise learning from deaths.

1.6. This standardised trust-wide process integrating mortality peer reviews into the governance framework will provide greater levels of assurance to the Trust Board and help to ensure that the organisation is using mortality rates and indicators alongside others such as incidents and complaints to monitor the quality of care and share good practice and learning from mistakes.

2. **Purpose**

2.1. The Standard Operating Procedure (SOP) has been written to provide guidance for all staff involved in mortality peer reviews including clinicians, clinical coding, governance, performance analysts, end-of-life and palliative care, and clinical audit and effectiveness staff.

2.2. The aim of the mortality peer review process is to:

- Identify and minimise ‘avoidable’ deaths in all Trust hospital sites
- Review the quality of end of life care
- Ensure that patients’ wishes have been identified and met
• Improve the experience of patients’ families and carers through better opportunities for involvement in investigations and reviews
• Identify and minimise avoidable admissions or late presentation
• Enable informed reporting with a transparent methodology
• Promote organisational learning and improvement

3. Definitions

Mortality rate

3.1. The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year.

Mortality peer review process

3.2. A structured methodology for retrospective case note review following a patient’s death to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

CRAB

3.3. Copeland’s Risk Adjusted Barometer - a system for assessing, monitoring and improving the quality of care, through predicting the clinical risk for individual patients with risk adjustment for complications which enables clinicians and the organisation to understand morbidity and avoidable harm.

4. Scope

4.1. This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the mortality review process:
• Medical Staff
• Senior Nursing Staff
• Clinical Coding Staff
• Clinical Audit & Effectiveness Staff
• Performance Analysts
• Quality Improvement Staff
• Governance Staff

4.2. The mortality peer review process is applicable to:
• All in-hospital deaths in all specialties
• Diagnosis groups identified by CQC/Imperial College Dr Foster Unit
• Diagnosis groups identified by the Mortality Review Committee
4.3. The mortality peer review process forms one aspect of the Trust’s quality improvement work. The aim is that all in-hospital deaths will be peer reviewed using the agreed mortality review proforma as outlined in the Trust’s Quality Account for 2015-2016.

4.4. In view of current temporary staffing constraints, the mortality peer review process will be phased in. The position will be reviewed in June 2017 to determine whether medical staffing issues have been addressed. Initially the process for Medical patients will include:

- 20 randomly selected deaths per month (out of approximately 40-50 medical deaths per month)
- Deaths related to inquests, incidents, complaints, physician concerns, CRAB data

5. Roles and responsibilities

5.1. The overall responsibility for the mortality peer review process sits with the Medical Director who will report outcomes and findings to the Trust Board.

Mortality Review Committee

The Mortality Review Committee will be responsible for:
- Providing assurance to the Trust Board on patient mortality based on review of care received by those who die
- Agreeing and approving the mortality review proforma
- Reviewing M&M outcomes, audit data and action plans
- Identifying areas of high risk and agreeing and monitoring improvement plans
- Ensuring that feedback and learning points are shared with the divisions and specialties so that learning outcomes and action points are included in the specialty audit programmes as appropriate

Deputy Medical Director

The Deputy Medical Director will be responsible for:
- Overall oversight and regular review of the mortality peer review process
- Identifying the relevant Associate Medical Director to ensure completion of the individual mortality peer review or mortality alert reviews as required
- Carrying out notes reviews with clinical coding where coding issues are identified

Associate Medical Directors

The Associate Medical Directors will be responsible for:
- Ensuring all deaths are reviewed using the mortality review proforma available on the Trust intranet, Bob
- Identifying clinicians to complete the mortality peer reviews and recording findings on the mortality review proformas
• Ensuring that patients’ families and carers are given an opportunity to be engaged with the review process, including providing feedback on the outcomes of the review as appropriate. (Advice on the process to follow is available in the Duty of Candour Policy or via the Governance Team)

• Ensuring that all pertinent cases and findings from mortality peer reviews are presented by the appropriate clinical leads at specialty Mortality & Morbidity (M&M) meetings

• Ensuring that outcomes and learning from M&M meetings are recorded and action plans for improvement are developed where required

• Ensuring that findings are evaluated and reported to specialty and divisional governance meetings to promote learning

• Overseeing progress on the implementation of action plans and keeping governance informed

• Feeding back findings from mortality peer reviews and M&M meetings to the Mortality Review Committee

Senior Nursing Staff

Senior Nursing staff will be responsible for:

• Participating in mortality peer reviews wherever possible, either in person or by nominated staff being available for advice on nursing issues

Clinical Coding Staff

Clinical Coding staff will be responsible for:

• Participating in mortality peer reviews where coding issues have been identified

• Routinely reviewing alerting diagnosis groups in Dr Foster from patient lists provided by the Performance Team each month

Performance Analysts

The Performance Analysts will be responsible for:

• Sending a list of Trust deaths to the Deputy Medical Director, Clinical Coding, Governance and Clinical Audit & Effectiveness which will include inpatient PAS/EHR information

• Requesting the patient notes and supplying the relevant patient details, including incident and post mortem information, to the Clinician nominated by the Associate Medical Director for individual reviews or where a diagnosis group has been highlighted by the CQC/Imperial College or the Mortality Review Committee

• Providing patient lists to the Clinical Coding Team each month where diagnosis groups are alerting in Dr Foster

Clinical Audit & Effectiveness Team

The Clinical Audit & Effectiveness Team will be responsible for:

• Producing reports based on information recorded in Keypoint

• Maintaining a library of completed peer review forms and feeding back the reports and outcomes to the clinical leads for each area

• Analysis of the database to identify themes and trends

• Recording special reviews on Keypoint
• Ensuring learning outcomes and action points are included in the specialty audit programmes as appropriate

**Governance Team**

The Governance Team will be responsible for:

• Recording known incidents, inquests and post mortems on the list of Trust deaths received from the Performance Department and notifying the Clinical Audit & Effectiveness Team

• Overseeing the process of mortality alert reviews and production of associated reports

• Monitor identified learning outcomes and associated action plans

• Support the review process with any identified duty of candour requirements

6. **Clinical coding**

6.1. Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a number of reasons, not least that it constitutes the raw data upon which decisions are made about the Trust’s income.

6.2. Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or hinder that process.

6.3. This is supported as part of the mortality peer review process through clinical coding staff involvement in the individual reviews and mortality alert reviews, guidance for clinical staff on the Trust intranet BoB, and other clinical coding training sessions.

7. **Process for carrying out mortality peer reviews**

7.1. The process for the conduct of mortality reviews is outlined in the flow chart at Appendix A. Key steps are described below:

**Notification of patient deaths**

• Patient deaths are notified through the Bereavement Support Office and/or the Performance Team, including post-mortem information where known

• Checks are made by the Governance Team against any incidents recorded on DATIX and these are noted

• At the end of each month, data of all in-hospital deaths that occurred together with incident and post mortem information is forwarded to the Deputy Medical Director for information and to the Associate Medical Directors who will be responsible for ensuring completion of the mortality peer reviews

• This data is also forwarded to the Clinical Audit & Effectiveness Team in order to prepare for the review process, including extracting coded data
Where concerns have been raised about a patient’s care and treatment, i.e. through an incident report or complaint, the mortality peer review should be carried out and used to inform any formal serious incident investigation.

If there is an identified duty of candour issue the mortality reviewers should act according to the guidance in the relevant Trust policy.

**Mortality peer reviews**

- The relevant Associate Medical Director should nominate peer reviewers to carry out the mortality reviews. They should also inform the Senior Nurse, Clinical Coding, Performance Team and Clinical Audit & Effectiveness of which clinicians have been nominated.
- The peer reviewer(s) should ensure that the patients’ family and/or carers have been contacted and given an opportunity to be engaged in the review. The Duty of Candour Policy contains advice on how to approach this.
- The reviews should be completed by the nominated peer reviewers and relevant senior nurse who should work together and carry out a holistic review of medical and nursing care.
- The findings of the mortality peer reviews should be recorded on the clinical audit mortality review proforma.
- All completed mortality peer reviews should be sent to the Clinical Audit & Effectiveness Team to collate and analyse.

**Clinical coding**

- Where clinical coding issues have been identified the notes should be sent to the Deputy Medical Director.
- The Deputy Medical Director and Clinical Coding will meet to review the notes and coding queries.
- Findings from this review should be fed back to the clinicians and clinical coders to promote learning and improvement in documentation and coding.

**Outcomes**

- Where concerns have been identified but no incident has previously been reported, the appropriate Associate Medical Director should be informed by the nominated peer reviewer and an incident report with brief details should be raised on DATIX to trigger further investigation.
- In addition, if there are found to be concerns about the standard of care then the case should be reviewed in-depth by a multi-disciplinary team at the regular departmental M&M meetings.
- Completed mortality peer reviews should be evaluated and the findings reported to the specialty M&M meetings and divisional governance days.
- Discussions, outcomes and learning from the M&M meetings, including conclusions about outstanding care and sub-optimal care, should be formally recorded and reported to the Mortality Review Committee.
Mortality peer reviews and in-depth reviews from M&M meetings should be used to inform any subsequent investigations, for example SEA, SIRI, complaint or legal claim.

Outcomes from the mortality peer review should be fed-back to the patient’s family and/or carers if that is their wish. Advice on the process to follow is available in the Duty of Candour Policy or via the Governance Team.

8. Process for responding to a mortality alert

8.1. If there are concerns about mortality in any particular patient group, (e.g. CQC alert, Dr Foster Unit at Imperial College, elevated SMR for a particular diagnostic group, or global high weekend mortality) it will be necessary to undertake an in-depth case note review.

Alert received

- The Performance Analyst should inform the Medical Director, Deputy Medical Director and Head of Performance.
- In addition, the Performance Analyst should notify the Governance Team of alerts received via the Dr Foster Unit at Imperial College in order that the Care Quality Commission (CQC) can be informed in a timely fashion once the results of the initial clinical coding review are known.

Clinical coding review

- The correct cohort of patients should be identified by the Performance Analyst, dependent on the source of the concern, and a list sent to Clinical Coding initially to check coding accuracy.
- If the result of the clinical coding audit is greater than or equal to 75% accuracy, this will trigger a full case note review.

Approval of full case note review

- The need for a full case note review should be approved by the Mortality Review Committee at their next meeting. The Committee should also identify appropriate consultant(s) to undertake the review and the cohort of patients whose care and treatment require review.
- The agreed cohort patient list should be collated by the Performance Analyst and sent to Clinical Audit & Effectiveness.
- Once the full case note review has been agreed, the CQC should be informed by Governance that a review is being carried out due to a diagnosis group flagging.
Case note reviews

- The Performance Analyst should request the relevant patient notes and ensure that the appropriate details including incidents and post mortem information are available to the case note reviewers
- An appropriate multi-disciplinary group should carry out the review, together with a lead with overall responsibility for the review and writing up the result
- Assessment of clinical coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care
- A review of the case notes for a reasonable consecutive sample of the patients who died (normally 30-40) should be undertaken in order to establish whether the clinical care the patients received was appropriate
- The care for each case should be recorded on the Trust mortality peer review audit proforma and sent to the Clinical Audit & Effectiveness Team to record on the Keypoint database

Reporting findings

- A report should be constructed demonstrating methodology, findings, learning and recommendations
- Reports from Performance (superspells and demographics of the whole cohort) and Clinical Audit (findings relating to the reviewed cases) should be produced to help populate the draft report with the relevant data
- The identified lead for the review should add appropriate narrative and finalise the report, liaising with the Deputy Medical Director and Governance for action planning
- The identified lead should present the draft report and findings to the Mortality Review Committee for approval

9. Mortality & morbidity meetings (M&M)

9.1. Participation in mortality and morbidity (M&M) meetings should be considered a core activity for all clinicians. Whilst it is recognised that different departments will have different requirements and aims in relation to M&M meetings, the main principles are that they should be a forum for discussion of deaths and other clinical adverse events.

9.2. The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. The M&M meeting has a central function in supporting services to achieve and maintain high standards of care.

9.3. For further information on the organisation and conduct of M&M meetings please see the associated M&M meetings standard operating procedure.
10. **Feedback to the frontline**

10.1. It is recognised that clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is therefore essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign.

10.2. Dashboards showing outcomes at individual / team / ward / department level will be developed and form part of the mortality review reports to divisions and the Mortality Review Committee.

11. **References**

- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England

12. **Associated Documentation**

12.1. Northern Devon Healthcare NHS Trust Policies for:

- Learning from mortality
- Mortality & Morbidity Meetings
- Duty of candour
- Investigation, analysis and improvement
APPENDIX A

In hospital death identified

Bereavement Support notifies:
Head of Corp Governance
Legal Claims – Inquests / PMs
CG Admin – Checks incidents

Peer reviewer completes
mortality review form

Concern identified?

NO

YES

Completed mortality review form
sent to Clinical Audit

Specialty records as an incident on
DATIX (if appropriate)

Random 10% sample of ‘no
concern’ deaths reviewed 6-
monthly at MRC

Escalation of incident and
consideration of whether it meets
SIRI criteria

NO

YES

Specialty conducts further in-
depth review to identify learning

Mortality review used to inform
SIRI investigation

Case discussed at specialty M&M
and divisional governance
meetings

All M&M minutes and ‘concern’
deaths discussed at MRC.
Discussions fed back to specialties