Document Control

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CONTENTS

1. Process for carrying out mortality peer reviews

1.1. The process for the conduct of mortality reviews is outlined in summary form in the flow chart at Appendix A. Key steps for identifying and reviewing deaths are described in full below:

1.2. Identifying deaths and collating information relevant to the mortality peer review process

Steps	Person/Team responsible	Timescales
Prospectively identify in-hospital deaths Add details to daily log of deaths with summary information including date, ward and responsible consultant; add related information on incidents, inquests and post mortems as it becomes available Share list via Learning from Deaths (LfD) electronic folder	Compliance & Risk Team Administrator in liaison with Bereavement Support Office	Continuously - as notified to Bereavement Support, with additional information added monthly by the third week of the following month
Retrospectively identify a list of deaths with summary information including date, ward and responsible consultant Share via email to Associate Medical Directors; Governance Facilitators; Senior Clinical Audit Facilitator and Data Collection spreadsheet in LfD electronic folder	Advanced Performance Analyst (mortality rates)	Monthly – in the first week of the following month
Retrospectively identify list of deaths with full set of relevant EHR details and completed coding for the first FCE Share via clinical audit file in LFD shared electronic folder	Advanced Performance Analyst (mortality rates)	Monthly – in the third week of the following month

1.3. Medical Examiner (ME) scrutiny.

The ME service is complimentary to the Trust mortality process. The Trust processes will ensure appropriate review of deaths that require further scrutiny.

Steps	Person/Team responsible	Timescales
Notify Medical Examiners of the death of a patient and provide patient records and summary information in line with national ME guidance	Medical Examiner Officer in liaison with Bereavement Support Office	Continuously
Agree the proposed cause of death and the overall accuracy of the medical certificate cause of death	Medical Examiner; qualified attending practitioners	Continuously
As part of the independent ME role, discuss the cause of death with the next of kin/informant, establishing if they have any concerns ; scrutinise cases as appropriate Record using recommended ME tools, escalating cases of	Medical Examiner with support of Medical Examiner Officer	Continuously

serious concern as appropriate		
Flag cases noted to require further review /investigation by the Trust Share via email to Deputy Medical Director/ Governance Facilitator/Associate Medical Director/Senior Clinical Audit Facilitator (mortality reviews) for incident investigations; ; share via email to Senior Clinical Audit Facilitator (mortality reviews) for SJRs	Medical Examiner	Continuously
Release patient notes to Clinical Coding Department upon completion of above	Medical Examiner Officer	Continuously
Share case numbers with the Trust's MRG Share numbers scrutinised, numbers reported to Coroner, numbers referred for SJR, and numbers reported as an incident, via email to Senior Clinical Audit Facilitator (mortality reviews)	Medical Examiner Officer	Monthly

1.4. Initial Structured Judgement Review (SJR) by a senior clinician/team of clinicians.

Steps	Person/Team responsible	Timescales
Identify cases for SJR **a) From cases referred by ME** **b) From priority groups, once coding has been completed**	Senior Clinical Audit Facilitator (mortality reviews)	Monthly, in the third week of the following month
Collate a sheet of electronic patient details relevant to the SJR for each inpatient case combining information from the datasets in 1.2 above	Senior Clinical Audit Facilitator (mortality reviews)	Monthly – in the third week of the following month
Allocate cases to senior clinician/team of clinicians for SJR when monthly information above is received or when individual cases are referred (eg the death of a patient with a learning disability)	Divisional Leads with support from Governance Facilitators and the Senior Clinical Audit Facilitator (mortality reviews)	Monthly, in the third week of the following month or as quickly as possible for individually referred cases.
Provide patient notes with sheet of electronic patient details to reviewers	Governance Facilitators for specialty reviewers; Clinical Audit Administrator for pool reviewers	Monthly according to reviewer capacity or as quickly as possible for individually referred cases.
Conduct an SJR, addressing issues raised by ME where relevant Record using Trust proforma (or nationally mandated tool), escalating serious concerns as appropriate	Mortality Peer Reviewers	Continuously according to reviewer capacity
Where serious concerns are raised by reviewers undertaking an SJR, determine whether immediate action is required, or whether the case can await a follow up specialty M&M review	Deputy Medical Director/Divisional Leads	As required
Monitor completion of SJRs and provide summaries to MRG	Senior Clinical Audit Facilitator (mortality reviews)	Monthly

Provide the Clinical Coding Department with a list of diagnosis and procedure recording/coding queries raised by Mortality Peer Reviewers in SJRs	Senior Clinical Audit Facilitator (mortality reviews)	Monthly
Investigate diagnosis and procedure recording/coding queries; update clinical coding as appropriate and feedback any trends identified to MRG, using them to inform quality improvement initiatives in documentation and coding	Clinical Coding Management Team	Monthly

1.5. Specialty M&M review with presentation, discussion and action planning.

Steps	Person/Team responsible	Timescales
Organise specialty M&M meetings either as standalone meetings or as part of broader Governance meetings, with support for formal minute taking	Divisional Leads/Governance Facilitators	Periodically according to meeting frequency agreed by Divisions
For medical inpatient specialties in which the majority of inpatient deaths occur, provide a summary of cases that have had SJRs since the previous meeting and Identify cases for specialty M&M follow-up. (SJRs in this group will usually have been completed by non-specialty pool reviewers). Arrange for notes to be provided	Senior Clinical Audit Facilitator (mortality reviews)	Periodically according to meeting frequency agreed by Divisions
Conduct follow-up reviews, referring to SJRs and case notes, presenting findings at relevant M&M meetings and identifying learning and actions as appropriate	Divisional Leads/Senior Clinicians allocated by Divisional Leads with input from specialty clinical staff at M&M meetings	Periodically according to meeting frequency agreed by Divisions
Submit Incident report on Datix for any cases in which the specialty M&M concluded that care was poor, or that an act or omission related to the death had occurred	Divisional Leads/Senior Clinicians allocated by Divisional Leads	As relevant, immediately following the M&M meeting
Finalise M&M meeting minutes, using Trust templates for recording patient-level M&M discussions as appropriate	Divisional Leads/Senior Clinicians allocated by Divisional Leads with support from Governance Facilitators	Periodically according to meeting frequency agreed by Divisions, *within 3 weeks of the meeting*
Carry out identified actions for improvement	Action Leads	As agreed
Distribute M&M minutes/key learning points to staff within specialty	Divisional Leads/Governance Facilitators	Periodically according to meeting frequency agreed by Divisions
Report a summary of findings and actions from specialty M&M meetings to Divisional Governance meetings and MRG	Divisional Leads	Monthly/bi-monthly
Summarise findings and outcomes from the mortality review process in reports to Board	Deputy Medical Director, Mortality Lead , Senior Clinical Audit Facilitator (mortality reviews), Advanced Performance Analyst (mortality rates)	Quarterly

1.6. Incident investigations resulting from the escalation of findings from mortality peer reviews will be undertaken, in liaison with families/carers as appropriate, following Trust policies on *Incident Reporting, Analysing, Investigating and Learning,* and *Supporting Staff Involved in an Incident, Complaint or Claim,* with outcomes from any resulting serious incidents (SI)s reported to MRG by *Divisional Leads /the Trust's Head of Quality and Patient Safety.*

1.7. Complaint investigations relating to the care of patients who have died will be undertaken in liaison with families/carers as appropriate, according to the Trust's policy on *Complaints, Concerns and Compliments*, with reference to completed mortality peer review findings. Outcomes will be reported to MRG by *Divisional Leads / Patient Experience Team.*

2. Patient groups that require separate mortality peer review arrangements

2.1. The death of a patient with a learning disability should be reported on Datix by a Learning Disability Specialist Nurse. A Senior Learning Disability Liaison Nurse will notify the Learning Disability Mortality Review Programme (LeDeR) programme. An SJR will automatically be triggered. This will be undertaken by a senior doctor and senior nurse allocated by the Deputy Medical Director. A specialty M&M review will be undertaken if concerns are identified.

2.2. The death of a patient aged under 18 should be reported according to paediatric team policies. A child death review will be led by a regional Child Death Overview Panel CDOP and entered onto the National Child Mortality Database. A case presentation should be given at the Trust's paediatric M&M meeting.

2.3. A stillbirth, perinatal or infant death should be reported according to maternity services policies. The case needs to be reported to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). The case should be reviewed using the Perinatal Mortality Review Tool (PMRT). A case presentation should be given at the Trust's perinatal M&M meeting.

2.4. A maternal death should be reported according to maternity services policies. The case needs to be reported to MBRRACE and the Healthcare Safety Investigation Branch (HSIB) who will conducted a full investigation. A case presentation should be given at the Trust's obstetric M&M meeting.

2.5. National reports of the themes and trends associated with the deaths of people with learning disabilities, perinatal and maternal deaths should be reviewed to determine local lessons to be learned from the nation-wide system of reviews with Trust specific action plans reported to the Clinical Effectiveness Committee, as is the case for other national reports.

3. Process for responding to mortality outlier alerts

3.1. If an external body (e.g. CQC, Dr Foster Unit at Imperial College, a national audit provider) notifies the Trust that it has identified concerns about mortality rates in any particular patient group, it will be necessary to undertake a specialised review with the following steps:

Steps	Person/Team responsible	Timescales
Share the outlier alert notice with the Medical Director, Deputy Medical Director, Mortality Lead, Head of Governance, Head of Performance, and Head of Quality and Patient Safety, copying in the Advanced Performance Analyst (mortality rates) , Senior Clinical Audit Facilitator (mortality reviews), and Clinical Coding Management Team	Person receiving the outlier alert notice	Immediately upon receipt
Establish a review team for responding to the alert, to include as a minimum, the relevant senior clinician, Advanced Performance Analyst (mortality rates) and Senior Clinical Audit Facilitator (mortality reviews) **Agree a plan of action with the review team, including nominating additional (multi- disciplinary) clinical staff as mortality peer reviewers if required** **Assess timescales for required response and liaise with alerting body as appropriate**	Deputy Medical Director	Within 3 days of receipt if possible
Identify relevant cases included in the alert notice	Advanced Performance Analyst (mortality rates)	Within 3 days of receipt if possible
Produce a preliminary report on the scoring of completed mortality reviews and share with the review team, Deputy Medical Director and Mortality Lead **Identify further cases requiring review; collate a sheet of electronic patient details relevant to the SJR for each inpatient case; and arrange access to patient notes for reviewers in liaison with Clinical Coding staff who may also require them**	Senior Clinical Audit Facilitator (mortality reviews)	Within 1 week of receipt if possible
Carry out preliminary advanced analysis of patient demographics and admissions (super-spells) using local EHR and HED data and share with the review team, Deputy Medical Director and Mortality Lead	Advanced Performance Analyst (mortality rates)	Within 3 weeks of response deadline if possible
If required, review the coding of identified cases, producing a preliminary report of findings (accessing notes in liaison with Clinical Audit staff who may also require them for SJRs) and share with the review team, Deputy Medical Director and Mortality Lead	Clinical Coding Management Team	Within 3 weeks of response deadline if possible
If required, conduct further SJRs on identified cases not yet reviewed, as appropriate	Relevant senior clinician/nominated clinical staff with support of Clinical Audit Administrator for notes	Within 3 weeks of response deadline if possible

	provision	
Produce a draft report combining EHR and HED analysis, clinical coding findings, an analysis of the final set of mortality reviews of all relevant cases, a record of relevant specialty M&M reviews and outcomes, and a proposed plan of recommended further actions **Share the draft report with alerting group project team, Deputy Medical Director and Mortality Lead for comment, (with further input from relevant specialty staff and MRG members if possible), and update as appropriate**	Relevant senior clinician with support of Senior Clinical Audit Facilitator (mortality reviews)	Within 2 weeks of response deadline if possible
Agree an action plan with relevant teams and managers	Relevant senior clinician with support of Deputy Medical Director	Within 1 week of response deadline if possible
Review and approve the final report and action plan for sign off by Medical Director	Deputy Medical Director, Mortality Lead	Within 1 week of response deadline if possible
Review and sign off the approved report and submit to the requesting body copying in Deputy Medical Director, Mortality Lead, alerting group team and Governance Manager	Medical Director	Within 1 day of response deadline
Ensure that actions are carried out within agreed timescales	Relevant teams and managers	As relevant
Monitor action plan completion, reporting regularly to MRG	Relevant senior clinician with support of Senior Clinical Audit Facilitator (mortality reviews)	Monthly

3.2. If MRG have concerns about mortality in any particular patient group from regular performance reports (eg. high SHMI rates), or from issues reported to MRG via other sources, a less formal specialised review will take place. This will usually involve reviews of the case notes for a reasonable consecutive sample of the patients who died in order to establish whether the clinical care the patients received was appropriate. The review process will be broadly in line with the steps for responding to a mortality outlier alert notified by an external body, as described above, but with MRG setting out the parameters of the review when it is initiated, and signing off the final report when it is completed.

3.3. 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 to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign. Findings of specialised reviews should be fed back at specialty or divisional governance meetings.

4. Mortality & morbidity meetings (M&M)

4.1. 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.

4.2. 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. It is important that the discussions and learning at M&M meetings are captured in formal minutes to provide evidence of mortality review outcomes; to track progress on actions; and to share learning with staff who were unable to attend the meeting. Templates for recording mortality review discussions have been recommended by MRG.

4.3. Review findings and learning outcomes agreed at M&M meetings should be shared through Divisional Governance structures and reported to MRG by Divisional Leads.

5. References and web links

Useful Links:

- NDHT mortality review profoma (SJR) https://ndht.ndevon.swest.nhs.uk/clinical-audit-and-effectiveness/mortality-review/
- Child Death Reviews https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
- Learning Disability Mortality Review programme (LeDeR) http://www.bristol.ac.uk/sps/leder/
- National Perinatal Review Tool https://www.npeu.ox.ac.uk/pmrt

References:

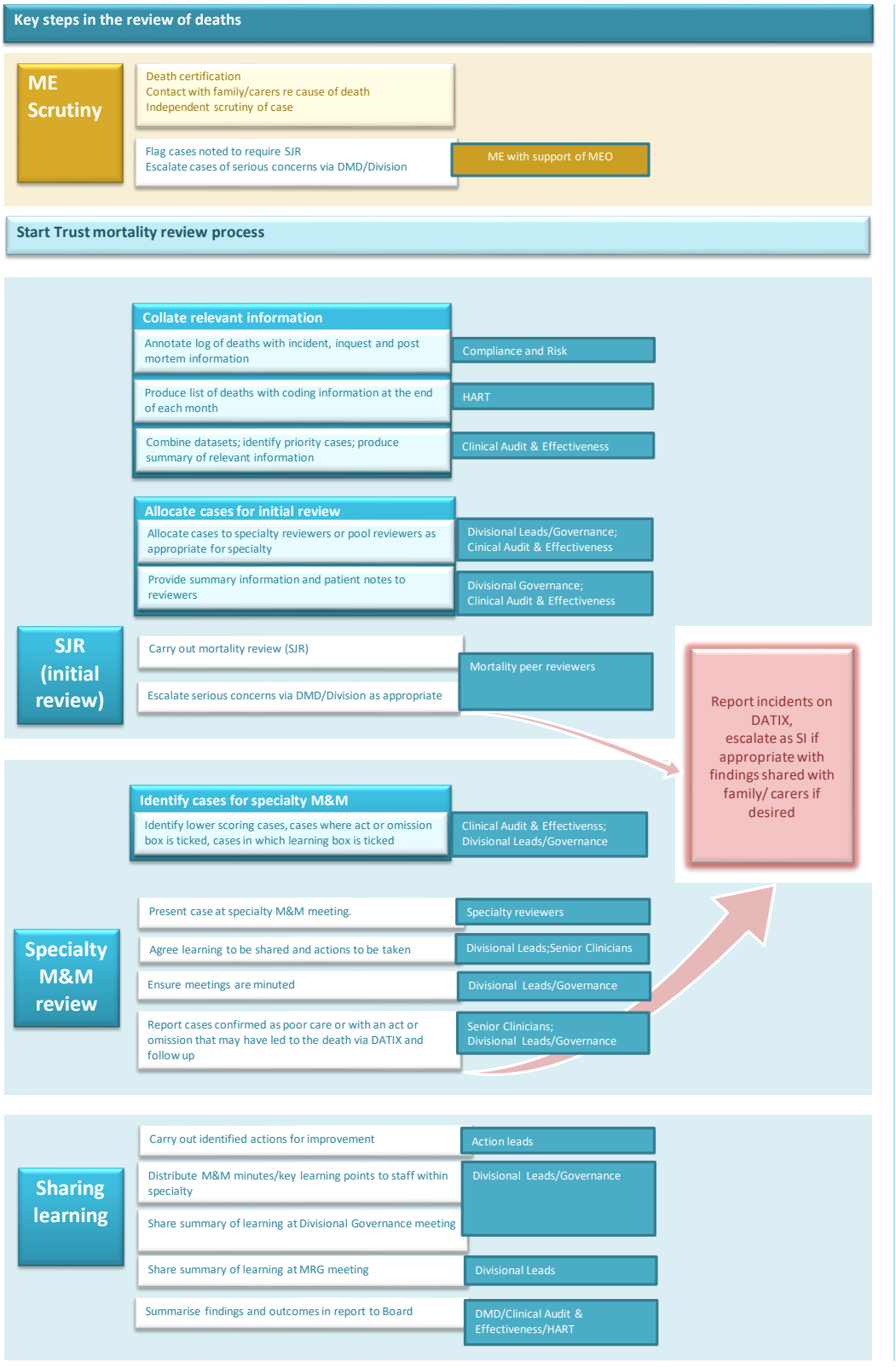
- Care Quality Commission (2016), Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability
- Care Quality Commission (2019), Learning from deaths: A review of the first year of NHS trusts implementing the national guidance https://www.cqc.org.uk/publications/themed-work/learning-deaths
- Higginson J, Walters R, Fulop N, *(*2012), Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?, *BMJ Qual Saf* https://qualitysafety.bmj.com/content/21/7/576
- Hogan H, et al (2012), Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study?, *BMJ Qual Saf* https://qualitysafety.bmj.com/content/21/9/737
- National Quality Board (2017) 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 https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- NHS Improvement, National Medical Examiner for England and Wales (2020) Implementing the medical examiner system: National Medical Examiner's good practice guidelines, NHS England and NHS Improvement. https://improvement.nhs.uk/documents/6398/National_Medical_Examiner_-_good_practice_guidelines.pdf

- Royal College of Surgeons (2015) Morbidity & Mortality Meetings: A guide to good practice https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/morbidity-and-mortality-meetings/

- Northern Devon Healthcare NHS Trust Policies and strategies for:
  - Learning from mortality
  - Complaints, concerns and compliments
  - Incident Reporting, Analysing, Investigating and Learning
  - Supporting staff involved in an incident, complaint or claim
  - Neonatal, maternal and child deaths

6. APPENDIX A

Flowchart



7. APPENDIX B

Background

7.1.1. Long established clinical audit and peer review processes incorporating analysis of mortality and morbidity have been used by clinical staff to improve patient safety. Specialty mortality and morbidity (M&M) meetings, established to review deaths as part of professional learning, have provided a forum for sharing findings from this work.

7.1.2. A more formalised process for mortality peer reviews has been put in place at Northern Devon Healthcare NHS Trust to 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. It has been informed by the National Quality Board (NQB) guidance published in March 2017, on how this should be done.

7.1.3. The main aim of the mortality peer review process is to identify opportunities for improving patient safety and enhancing the quality of care. Concentrating attention on any learning from problems in care identified in the period leading up to a patient's death 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. Retrospective case note reviews also help to gain an understanding of the care delivered to those whose death is expected and inevitable to ensure that they receive optimal end of life care. Through such reviews, examples of good practice can be identified and shared.

7.1.4. The process covers the selection of cases for different levels of review and the tools to be used in conducting reviews. It also describes how findings are to be shared, and escalated if necessary, by integrating the mortality review process into The Trust's incident reporting processes and developing governance structures.

7.1.5. In addition, a new medical examiner role is being rolled-out across England and Wales. Going forward, this role should enhance the scrutiny of the care of patients prior to death, improve death certification, and enable greater engagement with bereaved families and carers in line with NQB recommendations.

7.1.6. A standardized trust-wide process that integrates mortality peer reviews into the governance framework, alongside findings on incidents and complaints, provides assurance to the Trust Board that the organisation is monitoring the quality of care, sharing good practice and learning from mistakes.

Purpose

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

7.1.8. The main aim of the mortality review process is to identify opportunities for improving patient safety and enhancing the quality of care. This can be broken down into the following objectives:

- Identify and minimise problems in the care provided preceding an inpatient death in all Trust hospital sites
- Review the quality of end of life care
- Share examples of excellent practice
- Ensure that patients' wishes have been identified and met
- Improve the quality of death certification

- Improve the experience of bereaved 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

Definitions

7.1.9. Mortality rates

7.1.10. 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. Risk-adjusted hospital mortality measures take into account various characteristics of patient populations that can impact upon their risk of dying or 'expected' rate of mortality. The actual number of deaths is expressed as a percentage of the 'expected' deaths, meaning that numbers over 100 are higher than the expected rate, and numbers lower than 100 are below the expected rate. These measures allow more valid comparisons between trusts to be made.

7.1.11. One risk adjusted hospital mortality measure is the HSMR (Hospital Standardised Mortality Ratio) which measures in-hospital mortality among patients admitted with one of a set of 56 conditions The SHMI (Summary Hospital-level Mortality Indicator) is also used to report on mortality at trust level. It includes the patients who die during their hospital stay and up to 30 days post-discharge. Dr Foster and HED (Health Evaluation Data) are examples of providers of hospital risk-adjusted mortality measures. They are based on data collected on trusts' electronic health records and submitted to NHS Digital. National clinical audits can also provide benchmarking information on mortality rates based on audit data submitted directly by trusts.

7.1.12. Alerting diagnostic groups

7.1.13. Alerting diagnostic groups are clinical coding groupings in which there appear to be comparatively high risk-adjusted mortality rates, compared to other trusts. A high rate may indicate problems with the delivery of care for patients being admitted into the trust with a particular condition. There may be other types of alerts relating to the demographic characteristics of patients, or aspects of their admission such as day of the week, or length of stay. Alerts can be influenced by data quality issues.

7.1.14. Mortality peer review

7.1.15. 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, highlight excellent practice, and identify learning, plans for improvement and pathway redesign, where appropriate.

7.1.16. There are 2 levels of mortality peer review at NDHT:

7.1.16.1. An initial Structured Judgement Review (SJR) by a senior clinician: This will be applicable for deaths of patients in certain priority groups and any cases recommended following ME scrutiny. For most adult deaths this will be carried out using the using the Trust's structured mortality review proforma. A shortened version of the form will be used for deaths in the Emergency Department as there is only one stage of care to review. For deaths of patients under 18, stillbirths and maternal deaths, nationally mandated review tools will be used.

7.1.16.2. Specialty M&M review with presentation, discussion and action planning: This will be applicable for any cases in which learning opportunities are identified at SJR. The Trust has recommended templates for recording patient-level M&M discussions.

7.1.17. The mortality peer review process links very closely with the Trust's incident reporting policies and associated duty of candour responsibilities.

7.1.18. Medical Examiner (ME)

7.1.19. Medical examiners are senior medical doctors who have undertaken specialist training in the legal and clinical elements of the death certification processes. Their role which involves close liaison with the local coroner's office, is to:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establish if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contribute to other clinical governance procedures

7.1.20. Mortality and Morbidity (M&M) meeting

7.1.21. M&M meetings have been traditionally held within hospital specialties for doctors of all grades and other clinical staff to discuss and learn from cases where there has been a problem or complication. They have also been used to present examples of excellent practice. At NDHT M&Ms can occur as stand-alone meetings or as a section of a wider governance meeting.

Scope

7.1.22. 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
- Bereavement Support Office (BSO) staff
- Clinical Audit and Effectiveness (CAED) staff
- Clinical Coding staff
- Governance Facilitators
- Compliance and Risk staff
- Healthcare Analytics and Reporting Team (HART) staff
- Medical Examiner's Office (ME's) staff
- Supportive and Palliative Care Team (SPCT) staff

7.1.23. The mortality peer review process is applicable to all in-hospital deaths with a focus on priority groups and deaths that occur within 30 days of discharge if there has been a complaint relating to care in the final episode. (Other deaths in community settings will be covered in due course)

7.1.24. Priority groups are identified in line with NQB national Guidance on Learning from Deaths guidance. They include:

- Deaths of patients with learning disabilities
- Deaths of patients with severe mental health needs
- Deaths of infants, children or young people
- Stillbirths
- Maternal deaths
- Deaths of patients where a significant concern has been raised by bereaved families or carers, or staff about the care received

- Deaths of patients in alerting diagnostic groups
- Deaths of patients who are not expected to die eg. relevant expected procedures
- Deaths in groups of patients prioritised by the Trust's Mortality Review Group (MRG) for patient safety or quality improvement reasons

7.1.25. The mortality peer review process forms one aspect of the patient safety and quality improvement work undertaken within the Trust's divisions. It is supported by a variety of teams working together across the organisation. The process is monitored by the Trust's Mortality Review Group (MRG) which reports to the Safety and Risk Committee. Quarterly 'Learning from Deaths' papers based on mortality peer review work are submitted to the Trust Board. An annual summary is included in the Trust's Quality Account.

7.1.26. The role of the medical examiner is a new one to the Trust. Once it is fully implemented, the mortality review process may need to be revised.

Roles and responsibilities

7.1.27. Medical Director (MD)

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

7.1.29. Mortality Review Group (MRG)

7.1.30. The Mortality Review Group will be responsible for:

- Providing assurance to the Trust Board on patient mortality based on an informed analysis of local mortality rates and reviews of care of those who die
- Agreeing and approving the mortality review process
- Reviewing local data on mortality rates to identify issues for further investigation or action, and agreeing groups for prioritisation in mortality peer reviews
- Reviewing feedback on data quality issues to understand the impact on mortality rates and moderate the response accordingly
- Monitoring the completion of mortality reviews including reviews of maternal, still birth and under 18 deaths undertaken using national processes
- Reviewing M&M outcomes and actions
- Reviewing trends in findings from SJRs alongside related actions to identify any apparent gaps
- Reviewing specialist mortality review reports required in response to internal or external mortality outlier notifications, and monitoring their action plans
- Receiving feedback from the Medical Examiner to identify issues for further investigation or action
- Receiving feedback from SI and complaints investigations relating to deaths.
- Sharing findings on the quality of end of life care with the End of Life Group
- Reviewing patient safety findings relating to deaths from other Trust groups

7.1.31. Deputy Medical Director (DMD)

7.1.32. The Deputy Medical Director will be responsible for:

- Chairing the Mortality Review Group
- Reporting to the Safety and Risk Committee
- Jointly overseeing and reviewing the mortality peer review process
- Jointly overseeing specialist review reports on alerting groups for external bodies and reports to the Trust Board

7.1.33. Trust Lead for Mortality

7.1.34. The Mortality Lead will be responsible for:

- Jointly overseeing and reviewing the mortality peer review process
- Jointly overseeing specialist review reports on alerting groups for external bodies and reports to the Board

7.1.35. Medical Examiner (ME)

7.1.36. The Medical Examiners, with Medical Examiner Officer (MEO) support, will be responsible for:

- Improving the quality of death certification
- Engaging with and being an accessible expert resource for qualified attending practitioners
- Providing independent scrutiny of non-coronial deaths
- Ensuring the appropriate direction of deaths to the coroner
- Flagging cases noted to require further review /investigation by the Trust
- Sharing case numbers with the Trust's MRG (eg. numbers scrutinised, numbers reported to Coroner, numbers referred for SJR, and numbers reported as an incident)

7.1.37. Mortality Peer Reviewers (Consultants and Senior Medical/ Senior Nursing Staff)

7.1.38. The clinicians nominated to undertake mortality peer reviews (working on reviews within their own specialty, or as part of a 'reviewer pool') will be responsible for:

- Undertaking SJRs, identifying areas for improvement or excellent practice and escalating concerns regarding incidents of poor care as appropriate
- Ensuring that the most up to date Trust mortality review proforma or mandated national review tool is used for recording review findings and that the findings are shared with the Clinical Audit and Effectiveness Department.
- Undertaking specialty M&M reviews, ensuring that medical and nursing viewpoints are considered, presenting findings to M&M meetings, identifying learning and actions and reporting incidents as appropriate

7.1.39. Divisional Leads

7.1.40. The Associate Medical Directors (AMDs) and Divisional Nurses, with support from Divisional Governance Facilitators and the Senior Clinical Audit Facilitator, will be responsible for:

- Ensuring that deaths are reviewed as required using the Trust's mortality review proforma or mandated national review tool
- Identifying clinicians to complete the mortality peer reviews and recording findings on the mortality review proformas
- 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 the Trust's Incident Reporting, Analysing, Investigating and Learning, and Supporting staff involved in an incident, complaint or claim policies are followed appropriately
- 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 Group

7.1.41. Clinical Coding Management Team

7.1.42. The Clinical Coding Management Team will be responsible for:

- Ensuring that deceased patient's admissions are coded in a timely way
- Routinely validating the coding of deceased patient's admissions
- Monitoring data quality issues relating to the coding of deceased patient's notes and providing reports to MRG
- Responding to recording and coding queries raised in individual mortality reviews
- Reviewing alerting diagnosis groups in Dr Foster from patient lists provided by the HAR Team each month
- Providing coding information for specialised mortality review reports
- Providing updates on planned coding changes that may impact upon mortality rate reporting to MRG
- Working with clinical staff on quality improvement initiatives relating to the recording and coding of diagnoses

7.1.43. Healthcare Analytics and Reporting Team (HART)

7.1.44. An Advanced Performance Analyst with a designated role for mortality rate reporting, will (with support from HART), be responsible for:

- Analysing local trends in the electronic health record (EHR)- based mortality rate data and providing reports to MRG highlighting issues of concern
- Producing monthly retrospectively identified lists of Trust deaths with relevant inpatient electronic health record (EHR) information
- Identifying patients and providing advanced analyses of EHR-based mortality data for specialised mortality review reports
- Contributing to Learning from Deaths Board reports and Quality Account summaries
- Liaising with external consultants regarding the provision of mortality rate reports
- Updating MRG regarding developments in mortality rate reporting.

7.1.45. Clinical Audit & Effectiveness Department (CAED)

7.1.46. A Senior Clinical Audit & Effectiveness Facilitator with a designated role for mortality review reporting, will (with support from the Clinical Audit Team), be responsible for:

- Compiling case information from various sources for SJRs
- Prioritising cases according to MRG guidance and notifying Divisional Leads/Governance Facilitators and non-specialty reviewers in the reviewer pool of reviews to be completed, providing notes where required
- Reporting ME case numbers to MRG
- Designing and managing the web based data collection system for SJRs, providing updates as required
- Monitoring the completion of SJRs, analysing their findings and providing reports to MRG
- Monitoring the completion of specialty M&M reviews
- Analysing mortality review findings and drafting reports for specialised mortality review reports
- Contributing to Learning from Deaths Board reports and Quality Account summaries

7.1.47. Governance Facilitators

7.1.48. Governance Facilitators will be responsible for:

- Notifying specialty reviewers of reviews to be completed, providing notes where required
- Assisting with the organisation of M&M meetings as required and ensuring that minutes are taken and finalised in a timely way
- Circulating M&M minutes/key messages to cascade learning through the division
- Ensuring that incident reporting processes are followed for appropriate cases identified through the mortality review process (ie. cases with poor care, or with an act or omission in the care of the patient that is likely to have contributed to their death)

7.1.49. Compliance and Risk Team

7.1.50. Compliance and Risk Team staff in liaison with the Bereavement Support Office (BSO) and the Medical Examiner Officers will be responsible for:

- Maintaining a prospective list of patients who have died in hospital annotated with related incident, inquest and post mortem information