Maidstone and Tunbridge Wells NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) policy and procedure

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Document history

Requirement for document:	This policy has been drafted in response to new National guidance on Learning from Deaths, as outlined in the external cross references below.
Cross references (external):	1. Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016. www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf 2. National Guidance on Learning from Deaths, National Quality Board, March 2017. www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf 3. Using the structured judgement review method Data collection form Supported by: Commissioned by: National Mortality Case Record Review Programme (England version). Royal College of Physicians (RCP), 2017. www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA 4. Letter dated 22.02.17 from Dr Kathy McLean and Professor Sir Mike Richards to all Medical Directors, setting out the requirements for Trusts in respect of the implementation of the new Learning From Deaths Guidance. The letter provides an initial indication of what the commitments mean for Trusts and Foundation Trusts, including new requirements that will come into effect from April 2017. https://minhalexander.files.wordpress.com/2016/09/cqc-nhsi-letter-to-trusts-17022204-learning-from-deaths.pdf 5. Kent Child Death Review process www.proceduresonline.com/kentandmedway/chapters/p_unexpect_death.html 6. Learning Disability Mortality review process (LeDeR) www.bristol.ac.uk/sps/leder/
Associated documents (internal):	• Being Open/Duty of Candour Policy and Procedure [RWF-OPPPCS-NC-CG2] • Quality Accounts (available via Trust Intranet) • Quality Strategy (currently in draft – on Q-Pulse, under revision) • Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] • Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] • Doctor's Handbook (available via Trust Intranet)

Keywords:	Mortality	SJR	Case record reviews
	Structured Judgement Review		

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Issue:	**Description of changes:**	**Date:**
1.0	New policy in response to national requirements.	September 2017

Policy statement for

Undertaking Mortality Case Record Reviews

This policy explains how the new Structured Judgement Review (SJR) process will be implemented within Maidstone and Tunbridge Wells NHS Trust (MTW). The policy will advise staff on how to undertake a mortality case record review, which documentation to use, in which circumstances an SJR is required and how the new process relates to previous systems and processes adopted by the Trust.

The new process is nationally prescribed and must be followed. The policy will explain how the new process links to revised mortality reporting, escalation of concerns and dissemination of learning.

In scope are all inpatients and Emergency Department (ED) patients who die whilst in the Trust's care, and patients who die within 30 days of discharge.

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1.0 Introduction and scope

1.1 Introduction

The process for undertaking mortality reviews has been changed within the NHS to align with a new system called the Structured Judgement Review (SJR) process.

All Trusts and Foundation Trusts are required to implement the revised guidance which replaces all previous systems and processes.

Structured Judgement Review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. Section 5 (Procedure) explains how the new system will operate.

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

1.2 What does the policy intend to achieve?

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. When mistake happen, providers working with their partners need to do more to understand the causes.

The purpose of reviews and investigations of deaths for which problems in care might have contributed is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

It is incumbent upon the Trust to have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Thrust staff should make it a priority to work closely with bereaved families and carers and ensure that that a consistent level of timely, meaningful and compassionate support and engagement is delivered ad assured at every stage, from notification of the death to completion of an investigation report and sharing any lessons learned and actions taken.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulties with the delivery of care. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management; and the outcomes of interventions.

The Care Quality Commission (CQC) state three key reasons why a Trust may decide to investigate the care provided before a patient's death. These are:

- **Learning**: To improve and change the way that care is provided.
- **Candour**: To support sharing information with others, including families.
- **Accountability**: If failures are found.

Through this policy, the Trust will support the development of enhanced skills and provide training to support this agenda. This will ensure that staff reporting deaths have the appropriate skills through specialist training to review and investigate deaths to a high standard.

1.3 Which staff does this policy apply to?

This policy applies to all clinical staff when conducting a mortality review structured judgement review (SJR). This process is primarily led by medical staff, with the support of all relevant members of the Multi-Disciplinary Team (MDT).

1.4 Which patients does this policy apply to?

This policy applies to all patients who have been cared for by Maidstone and Tunbridge Wells NHS Trust. In addition the following patients will also adhere to the previously prescribed investigatory processes (see Cross references and Appendix 6) for:

- Paediatrics – the Child Death Review process
- Maternal Deaths, Still births and infant deaths - the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) review process
- Learning Disabilities – the LeDeR process

2.0 Definitions / glossary

Abbreviation	Definition
CQC	Care Quality Commission
DoC	Duty of Candour. NHS providers are required to comply with the duty of candour, meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong
Dr Foster	Dr Foster works across health economies to monitor and benchmark performance – nationally and globally – against key indicators of quality and efficiency, drawing on multiple datasets in innovative and pioneering ways.
EPR	Executive Performance Review. A monthly performance review of each Division in the Trust, Chaired by the Chief Executive or nominated Executive Director, conducted against the Trust's Performance Framework
Infokiosk	Maidstone and Tunbridge Wells database where performance dashboards can be accessed
KPIs	Key Performance Indicators

Abbreviation	Definition
MDT	Multi-Disciplinary Team. Multi-disciplinary teams are made up of a variety of expert healthcare professionals who have specialised knowledge and training in specific areas. The teams meet regularly to discuss individual cases and to plan the best course of treatment for the patient. MDTs improve communication and decision making, waiting times and patient care
MSG	Mortality Surveillance Group. A group of senior Clinicians and Managers that meets monthly, chaired by the Deputy Medical Director to support the Trust in providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated, with learning disseminated and actions implemented to improve outcomes
MTW	Maidstone and Tunbridge Wells NHS Trust
RCP	Royal College of Physicians
SI	Serious Incident. An incident requiring investigation, as described in the National Framework for Reporting and Learning from Serious Incident
SJR	Structured Judgement Review. Trained reviewers assess the healthcare record in a critical manner and comment on specific phases of clinical care using the new Royal College of Physicians process and recording form for completing mortality reviews, upon which this policy is based
TCGC	Trust Clinical Governance Committee
The Trust	Maidstone and Tunbridge Wells NHS Trust
TME	Trust Management Executive. The senior management committee within the Trust.

3.0 Duties

3.1 Executive and management responsibilities

- **Duties of the Trust Board**
  Authority and responsibility for governance and for establishing, supporting and evaluating the Trust's mortality process rests with the Trust Board. The Trust Board remains the primary point of assurance on mortality.

  The Board has the following responsibilities:
  - Ensuring a Lead Non-Executive and Executive Director are assigned.
  - From April 2017, Trusts have been required to collect and publish (on a quarterly basis) specified information on deaths. This should be through a report and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach with publication of the data and learning points. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. This data must be presented via the mortality dashboard **(Appendix 4)**.
  - The Board, with support from the Lead Non-Executive and Executive Director must ensure that the organisation:
    - Pays particular attention to the care of patients with learning disabilities or mental health needs.
    - Ensures a robust system for identifying deaths requiring review.
    - Has an effective methodology for case record reviews and that these are carried out to a high quality.
    - Ensures that mortality reporting (reviews, investigations and learning) is regularly provided to the Board.
    - Ensures that learning from reviews is acted upon to change organisational practice and improve care.
    - Ensures that learning from deaths is reported in the annual Quality Accounts.
    - Shares learning across the organisation and with other services where the learning could be useful.
    - Ensure that there is a sufficient number of staff with the right skills to review and investigate deaths in a timely manner.
    - Offer timely, compassionate and meaningful engagement with bereaved families and carers in all stages of the process.
    - Instigates independent investigations where appropriate.
    - Works with commissioners to review and improve processes and approach.
- **The Lead Non-Executive Director** is required to take oversight of the process.

3.2 Executive accountabilities

- **The Chief Executive,** as Accountable Officer, carries overall responsibility for the quality and standards of care delivered by the Trust. The Chief Executive is therefore responsible for ensuring that systems are in place and functioning effectively in respect of the mortality agenda. The Chief Executive is also required to sign the Annual Quality Accounts, in which the specified information on deaths is required to be summarised.
- **The Medical Director** is ultimately accountable for the implementation of the Trust wide mortality review process and monitoring of mortality data received by the Trust. The Medical Director is also ultimately responsible for ensuring clinical effectiveness across the organisation and for ensuring that staff adhere to this policy. The Medical Director is also responsible for ensuring that monthly mortality review meetings are held and that corporately, lessons learned and all actions are implemented.
- **The Chief Nurse** is the CQC Nominated Individual within the Trust. The Chief Nurses' responsibility is respect of mortality reviews is to ensure that all activities relating to mortality comply with CQC regulations.
- **The Deputy Medical Director (Planned Care)** is responsible for chairing the Mortality Surveillance Group and ensuring that all mortality alerts and concerns are addressed appropriately. The Deputy Medical Director (Planned Care) also reports on mortality outcomes to the Quality Committee and the Trust Management Executive.

3.3 Management responsibilities

- **The Associate Director for Quality Governance** is responsible for the production of this policy (the author) and for ensuring that the appropriate governance arrangements exist to safeguard the quality of the systems and processes that contribute to the care of patients. The Associate Director for Quality Governance is also responsible for the mortality review process within the Trust and for embedding a culture of organisational learning from mortality reviews.
- **The Associate Director of Business Intelligence** is responsible for production, supply, interpretation and alerting of all data relevant to the mortality agenda. The Associate Director of Business Intelligence is also the point of liaison between the Trust and the Dr Foster data provider, undertaking a two-way challenge of the data and assurance of interpretation and understanding any data anomalies. The Assistant Director of Business Intelligence is also responsible for the provision to data to the Divisions/Directorates and the Trust's monthly Executive Performance Review (EPR) process.

- **The Divisional Management Teams** are responsible for ensuring that all specialties review all deaths occurring under their care and discuss the findings from mortality reviews as part of the Directorate clinical governance process. The Divisional Management Teams are also responsible for the timely completion of all SJRs and ensuring that these are submitted to the Trust's Clinical Governance Administrator as per the Trust's key performance indicators (KPIs) which are aligned to the Trust's EPR process. Divisional Managers should ensure that they have key staff in place and they are fully trained to undertake their roles. The Divisional Management Teams also have responsibility to adequately address and escalate any concerns raised by bereaved families and/or carers (see section 5 – Procedure).

3.4 Operational staff

- **The Directorate/Speciality Mortality Leads** are responsible for the development and delivery of the Trust-wide mortality review process within their specialties by ensuring that all reviews are completed in line with the standards described in this Policy and Procedure and any areas identified for improvement are addressed. They are also responsible for monitoring their mortality data which is available through the Trust's InfoKiosk and through the specialty reports from Dr Foster, taking action as appropriate. Mortality Leads will also report their Directorate reviews to the Mortality Surveillance Group (MSG) on a monthly basis, providing feedback on learning which has arisen from mortality reviews. The Directorate Mortality Leads are also responsible for the proactive escalation of any mortality review that reveals a potential Serious Incident (SI). Directorate Mortality Leads are already in post.
- **The Consultant Staff** are responsible for:
  - completing mortality reviews within their specialty as appropriate. The review should be conducted by clinicians who were not directly involved in the patient's care.
  - ensuring that mortality reviews provide an accurate record of care containing clear and relevant documentation.
  - ensuring that any reviews that they have been nominated to undertake by the MSG are completed and reported back within the specified timescale to the MSG. Involvement in mortality reviews allows for Consultants to reflect upon their own and their teams' practice.
  - ensuring that SJRs are carried out in line with this Policy to safeguard any learning that has been determined and to also oversee prompt implementation of that learning.
  - Ensuring that relatives and/or carers of all patients who have died in their care are notified of the Trust's responsibility to undertake a mortality review under its Duty of Candour (DoC) requirements should a failure in care be identified in the review process. The Consultant Lead for the SJR will liaise with the family/carers under the Trust's DoC process. Please refer to the Trust's Duty of Candour Policy (RWF-OPPPCS-NC-CG2) for further information.

- **Nurses, Allied Health Professionals and other clinical staff.** All healthcare professionals are required to be involved in SJRs as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews which may affect their area of practice, to full involvement in the production of data and implementation of recommendations.
- **Junior Doctors** are responsible for
  - completing the death certificate accurately
  - Completion of the Preliminary Screening Form (Appendix 4)
  - Completion of the discharge summary to notify the patient's General Practitioner (GP) of the patient's death.
- **The Bereavement Team** are responsible for helping families and carers through the practical aspects following the death of a loved one such as:
  - arranging completion of all documentation, including medical certificates;
  - the collection of personal belongings;
  - post mortem advice and counselling;
  - deaths referred to the coroner;
  - emotional support,
  - collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
  - advising the family/carer of the Trust's responsibility, under its Duty of Candour requirements, to undertake a mortality review of all patients who have died.
  - If no failures in care are identified, advising the family/carer of this outcome. The Bereavement Team will be advised of this outcome by the Clinical Governance Administrator.

  The Bereavement Team are also responsible for acting as a conduit to escalate information (in line with the procedure outlined in section 5 of this document) regarding bereaved families and/or carers who are have concerns about the care and/or treatment of the deceased patient.

3.5 Trust committees

- **The Quality Committee:** The Quality Committee will receive a mortality update.
- **Trust Management Executive (TME)** is the senior management committee within the Trust. Its purpose is to:
  - Receive and where appropriate, discuss the monthly Mortality dashboard and any ensuing actions.
  - Receive the report from the Trust Clinical Governance Committee and where appropriate, discuss and review any key actions relating to mortality.
- **Trust Clinical Governance Committee (TCGC)** is the committee which aggregates and monitors all clinical governance activity within the Trust. Its purpose is to monitor and support clinical governance activity and performance and to monitor quality standards including compliance with national standards and regulations. As such it will:
  - Review the Trust's mortality dashboard and ensure that action is being managed via the Mortality Surveillance Group
  - Review any identified risks and exception reports, make recommendations for actions and escalate where appropriate

- **Mortality Surveillance Group (MSG)** is responsible for supporting the Trust in:
  - providing assurance that all hospital associated deaths are proactively monitored, reviewed, reported and where necessary, investigated, lessons learned and actions implemented to improve outcomes.
  - acting as the principal source of advice and expertise to the Trust on mortality.
  - providing updates on the status of completed investigations, latest mortality data and any areas of concern arising to the Trust Clinical Governance Committee.

4.0 Training / competency requirements

National Training on SJRs has been arranged for Trust's Clinical representatives. These Clinical Representatives have been nominated by the Medical Director and are from a cross-section of clinical disciplines within the organisation. A Trust-wide rollout programme is being devised to cascade this training which will take place in October 2017. The clinicians who attend the National training programme will, in turn, train a team of Trust-level trainers who will act as a resource to roll out the Trust-wide training programme. The training will be co-ordinated by the Learning and Development Team. Ongoing training and support will be provided via the Divisions and Directorates once the rollout programme has been completed. The Training Programme will be available from the end of October 2017, via the Learning and Development Department.

Department name	**Contact telephone number**
Learning and Development	Ext: 24215 (Maidstone Hospital)

5.0 Procedure

5.1 Procedure overview:

There are two stages to the review process.

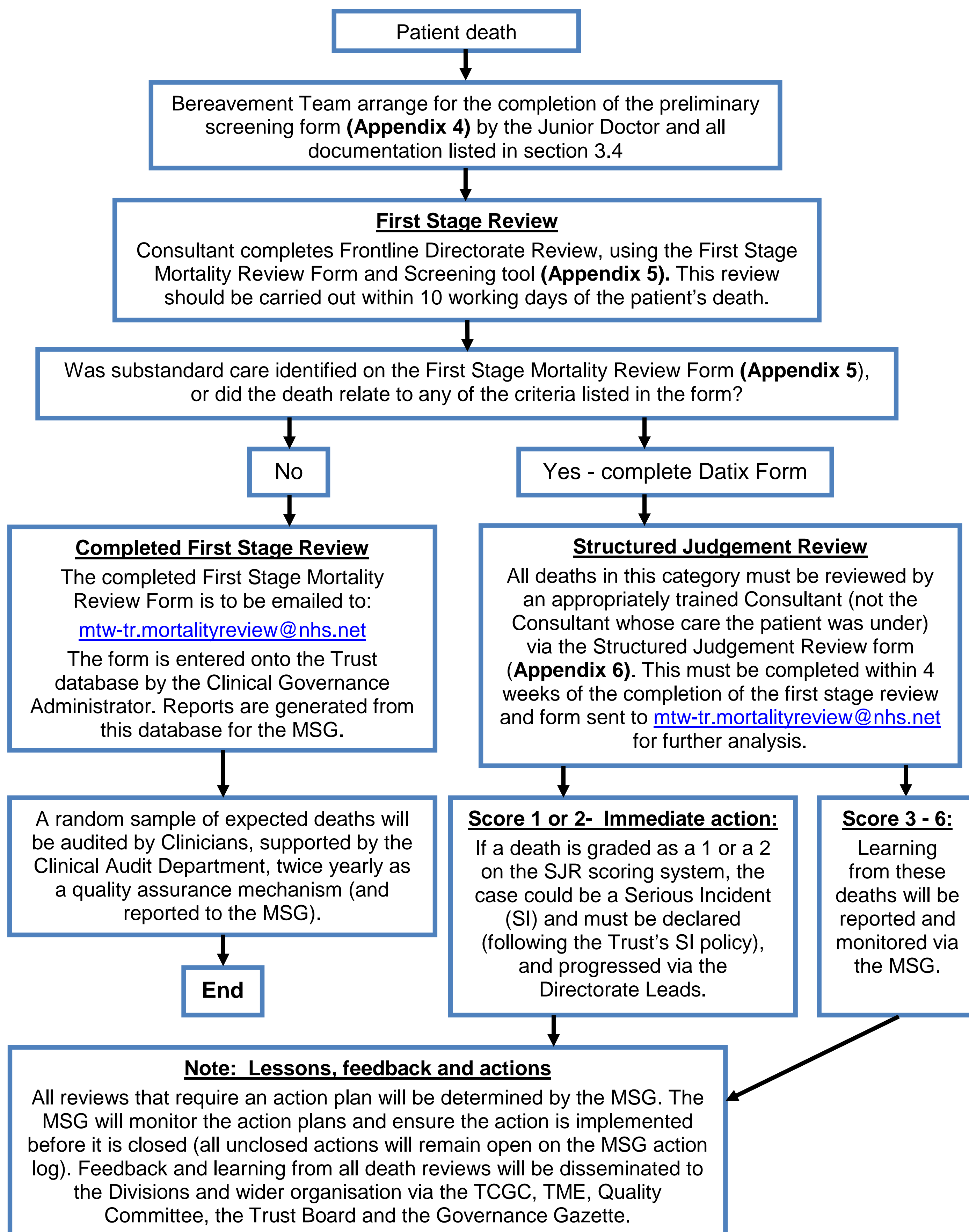
- Stage 1 (the frontline review)
- Stage 2, (the structured judgement review).

The flowchart below outlines the stages in the review process. In scope are all inpatients, ED patients and patients who die within 30 days of discharge. Patients in the following category should proceed straight to an SJR:

- All patients with learning disabilities of diagnosis of mental illness, unexpected deaths from a simple intervention e.g. elective surgical procedures
- Deaths in a service with an alert raised which when reviewed would provide learning
- Deaths to support learning and improvement.
- In line with existing national process, all deaths in patients who have a diagnosis of a learning disability must be notified to the LeDer system, by the person who completes the death certificate, in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300-777-4774, and also to the West Kent CCG Quality Team on 01732 375273.

On the following page is a flowchart which explains the mortality review process.

5.2 Mortality review procedure



5.3 First-stage review:

The first stage is mainly the domain of what might be called 'front line' reviewers; Consultants who undertake reviews within their own services or Directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as a part of a team looking at the care of groups of cases. The majority of reviews are completed at this point. The first-stage review will be informed by the Preliminary Screening Form (**Appendix 4)** when the death certificate is completed in the Bereavement Office.

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that if certain criteria are present, NHS organisations must undertake a case record review of a patient's care, with a view to developing an understanding of themes relating to mortality, in order to drive quality improvement work. The mandatory criteria, indicating case record review is necessary, are present in the form (**Appendix 5).** This form should be used as explained in section 5.2.

If 'YES' is selected in any of the criteria fields, this will trigger a full SJR review and the procedure outlined in the flowchart in section 5.2 of this policy document must be followed.

The data provided on the form will be used to help the Trust develop an understanding of themes relating to mortality, in order to drive quality improvement work.

At the end of the form will be used to help the Trust develop an understanding of themes relating to mortality, in order to drive quality improvement work.

At the end of the form, the reviewer is asked to check if they have selected "yes" to any of the mandatory criteria. In these instances, the Directorate or Specialty Mortality Lead must be informed and this will trigger a case note review. Please refer to the flowchart in section 5.2.

5.4 Second-Stage Review:

A second-stage review is undertaken where care problems have been identified by a first-stage reviewer or a positive response has been given to any of the criteria boxes on the form in **Appendix 5** (where an answer of 'YES' has been given). This second stage review is undertaken within the auspices of the Trust's Clinical Governance process and it uses the same review methodology as the stage 1 process, but with the additional option of judging the potential avoidability of a death where sub-optimal care has been identified.

Second-stage reviews are undertaken using the structured judgement method by those trained in this method. This form is the Royal College of Physicians' recommended tool for conducting SJRs and against which, all national training is being given. This form can be found at **Appendix 6.** It is a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the first-stage review (with poor or very poor overall scores and/or where actual harm or harms are judged to have occurred), the MSG may decide on an additional assessment of the level of the potential avoidability of the patient's death.

Judging the level of the avoidability of a death involves a complex assessment. The narrative allows for themes to be developed that act as a focus for the next improvement steps. This approach also has the benefit of enabling individuals to learn from, and recognise, the cases where care has gone well. The judgement is framed by a six-point scale (where 6= Definitely not avoidable; and 1 = Definitely avoidable). In addition, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

Making an overall summary judgement on whether a death was avoidable (at least to some extent) is often a challenging process that goes beyond judging safety and quality, by also taking into account comorbidities and estimated life expectancy. Nevertheless, experience in some hospitals suggests that a combination of an 'avoidability' score and an explicit judgement statement may enhance the information provided in this second-stage assessment. The avoidability scale is found in **Appendix 6** on the last page together with an avoidability of death judgement comment. A score of 1 or 2 on the scale would indicate 'cause for concern'. As set out in the flowchart in section 5.2, this may result in a formal SI investigation.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

Compliance with this document will be monitored as follows:

- Review of KPIs of completed mortality reviews via the Trust's Executive Performance Review process and the Mortality Surveillance Group.
- Monitoring of the proportion of the number of cases referred for a full Structured Judgement Review via the Trust's Executive Performance Review process and the Mortality Surveillance Group.
- The monitoring of the quality and standard of the completed of the forms via the MSG review process.
- A six monthly audit cycle of a random sample of expected deaths that do not progress to a full SJR review.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 3 years, following the procedure set out in the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken.

If minor amendments are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Minor amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'. For a full explanation please see the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25]. The amended document can be emailed to the CGA for activation on the Trust approved document management database on the intranet, under 'Policies & guidelines'. Similarly, amendments to the appendices between reviews do not need to undergo consultation, approval and ratification.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Associate Director, Quality and Governance

By date: 4th September 2017

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant	17/08/2017	17/08/2017	Y	Y
Chief Pharmacist and Formulary Pharmacist	22/08/2017	Nil	N	N
Head of Staff Engagement and Equality	22/08/2017	23/8/2017	N	N/A
Health Records Manager	22/08/2017	Nil	N	N
Complaints & PALS Manager	22/08/2017	05/09/2017	Y	Y
All individuals listed on the front page of this document	22/08/2017	Nil	N	N
All members of the approving committee: Trust Clinical Governance Committee	22/08/2017	Nil	N	N
Other individuals the author believes should be consulted:				
All members of the Mortality Surveillance Group	22/08/2017	Nil	N	N
Executive Directors	22/08/2017	Nil	N	N
Clinical Directors	22/08/2017	Nil	N	N
Deputy Medical Directors	22/08/2017	Nil	N	N
Director of Medical Education	22/08/2017	Nil	N	N
Heads of Services	22/08/2017	Nil	N	N
DDOs/HoNs	22/08/2017	Nil	N	N
GMs	22/08/2017	Nil	N	N
Matron (Surgery & Urology)	22/08/2017	23/08/17	Y	Y

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Undertaking Mortality Case Record Reviews (including Structured Judgement Reviews) Policy and Procedure
What are the aims of the policy or practice?	To advise all clinical and managerial staff on the revised National procedural requirements for undertaking mortality reviews.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	The National process identifies the following vulnerable patient groups as being required for inclusion to ensure that any potential adverse impact of their death is investigated appropriately: *Patients with Learning disability *Patients with a mental health diagnosis Evidence source – Learning From Deaths NQB March 2017.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Preliminary screening form	RWF-GQU-GOV-FOR-2	This policy
5	First-stage mortality review form and screening tool	RWF-GQU-GOV-FOR-3	This policy
6	Structured Judgement Review form	RWF-GQU-GOV-FOR-4	This policy

NHS
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NHS Trust

Preliminary screening form

Who was the Consultant responsible for the patient during last admission (at time of death)?

Dr / Mr / Miss / Ms / Prof ……………………………………..

Has this case been referred to the Coroner? Yes / No

Did this patient have a history of learning disabilities? Yes / No

Did this patient have a history of mental health issues? Yes / No

Have the family/carers raised any concerns about care during the last admission? Yes / No

To your knowledge or those of the medical / surgical / nursing teams caring for this patient were there any issues with the care this patient received during their admission?

Cause of death has been certified as:

1a

1b

1c

2

Was the cause of death discussed with the patient's Consultant (or a designated Dr on part 2 of the rota) before the certificate was completed? Yes / No

Any other comments to inform the mortality review?

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The master copy is held on Q-Pulse Document Management System
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NHS
Maidstone and Tunbridge Wells
NHS Trust

First stage mortality review form and screening tool

NAME	
DOB	
NHS NUMBER	

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that certain criteria are present, NHS organisations must undertake a case record review of a patients care, with a view to develop an understanding of themes relating to mortality, in order to drive quality improvement work.

The mandatory criteria indicating case record review is necessary are present in the fields below. Please use this form as explained in section 5 of the Trust's 'Undertaking Mortality Case Record Reviews (SJR) Policy and Procedure'.

If 'YES' is selected in any field, this will trigger a full SJR review and the procedure outlined in the flowchart in section 5.2 of the Policy document must be followed.

SPECIALTY	
CONSULTANT undertaking review	
CONSULTANT responsible for care	

Cause of death (death certificate completed as):

1a	
1b	
1c	
2	

Criteria for Case Record Review	Yes	No
1. Was the death unexpected? There will be some patients with frailty and multiple comorbidities in whom death was not considered to be unexpected by the clinical team - these do not require case record review unless other concerns are present.	☐	☐
2. If the death was expected, was there an absence of end of life care planning or DNACPR form?	☐	☐
3. Are you concerned that any problems in healthcare occurred? A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm' e.g. Avoidable healthcare associated infection, avoidable acquired pressure ulcer, failure to respond in a timely manner to deterioration etc.	☐	☐
4. Have you any concerns that this death was avoidable? Even if you have slight concerns that this death was avoidable, you should refer for Structured Judgement Review	☐	☐

Criteria for Case Record Review	Yes	No
5. Is this case subject to an investigation (internal or external)? i.e. when an incident with moderate harm or above has been reported on Datix	☐	☐
6. Did the family/carers have significant concern regarding the quality of care provision in hospital? i.e. cases in which the family/carers have made a complaint	☐	☐
7. Was the patient admitted for an elective procedure?	☐	☐
8. Was this death reported to the coroner? (Including if the patient died whilst sectioned under the Mental Health Act). Excluding when reporting industrial diseases	☐	☐
9. Did this patient have a learning disability?	☐	☐
10.Was a safeguarding concern raised?	☐	☐
11.Did this patient have a recognised mental health condition?	☐	☐
For Structured Judgement Review? (If yes to any of the above then a review is required) You may wish to put this case forward for an SJR for another reason. If so please expand here:	☐	☐
If a Structured Judgement Review is not required are there any aspects of excellent care or compliments received you wish to highlight?		
Any further comments to aid senior review?		

The data you have provided will be used to help the Trust develop an understanding of theme relating to mortality, in order to drive quality improvement work.

CHECK: If you have selected "Yes" to any of the mandatory criteria above, your specialty's Mortality Lead will be informed and this will trigger a Structured Judgement Review.

Please send completed forms to mtw-tr.mortalityreview@nhs.net

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National Mortality Case Record Review Programme
Structured Judgement Review Form:

Please enter the following:

Age at death (years):

Gender:

First part of the patient's postcode (e.g. ME15):

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between attendance and death:

Month cluster during which the patient died:
Jan/Feb/Mar *Apr/May/Jun* *Jul/Aug/Sept* *Oct/Nov/Dec*

Specialty team at time of death:

Specific location of death:

Type of admission: Elective/Non-Elective:

The certified cause of death (if known):

1a

1b

1c

2

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Guidance for reviewers

1. Did the patient have a learning disability?

   - No indication of a learning disability.
     Action: proceed with this review.
   - Yes – clear or possible indications from the case records of a learning disability.
     Action: Please ensure that this case was referred to the LeDeR team in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300 777 4774, and also to the West Kent CCG Quality Team on 01732 375273 when the Death Certificate was completed. Make arrangements in regard to who is undertaking the review.

2. Did the patient have a diagnosed mental health condition?

   - No indication of a mental health condition.
     Action: proceed with this review.
   - Yes – clear or possible indications from the case records of a severe mental health issue.
     Action: after your review, please refer the case to the Mortality Surveillance Group.

3. Is the patient 18 or older?

   - Yes the patient is 18 years or older.
     Action: proceed with this review.
   - No – the patient is under 18 years old.
     Action: the Kent Child Death procedures must be followed.
     - Form A to be completed on line as soon as possible after confirmation of a child death using the following link – this will notify the Child Death Review Team – https://www.qes-online.com/Kent/eCDOP/Live/Public
     - For any concerns/queries - contact the Child Death team on **03000 41 71 25** or email cdop@kent.gov.uk
     - Kent Procedures http://www.proceduresonline.com/kentandmedway/chapters/p_unexpect_death.html
     - Ensure that the Named Doctor for Child Death and the Named Nurse Safeguarding Children are informed.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether this was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase. **1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care** Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase. **1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care** Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase. **1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care** Please circle only one score.

Please rate the quality of the patient healthcare record **1 = Very poor 2 = Poor 3 = Adequate 4 = Good 5 = Excellent** Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (proceed to next page) **Yes** ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1 **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2 **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*
Yes ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3 **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4 **Problem with infection management Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5 **Problem related to operation / invasive procedure** *(other than infection control)*
Yes ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6 **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7 **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8 **Problem of any other type not fitting the categories above - Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351:h3239. DOI: 10.1136/bmj.h3239

Avoidability of death judgement score

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 No evidence of avoidability

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

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