King's College Hospital NHS
NHS Foundation Trust

# Mortality Monitoring Policy

| Document Information | | | |
|---|---|---|---|
| **Version:** | 3.0 | **Date:** | 25/07/2016 |
| **Ratified by:** | King's Executive | | |
| **Date ratified:** | 31 July 2017 | | |
| **Author(s):** | Claire Palmer, Head of Patient Outcomes<br>William Bernal, Assistant Medical Director | | |
| **Responsible Director:** | Jules Wendon, Executive Medical Director | | |
| **Responsible committee:** | Mortality Monitoring Committee | | |
| **Date when policy comes into effect:** | 07 August 2017 | | |
| **Review date:** | 07 August 2020 | | |
| **Target Audience:** | All clinical staff | | |
| **Location of document:** | *http://kingsdoc/docs/policies* | | |

# Document History

**Document replaces:** Mortality Monitoring Policy version 2.0, 16/06/2016

**Replaced document archive location:**
http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Mortality Monitoring Policy.doc

## Consultation distribution (before ratification)

| Sent to | Version | Date | Actions taken as a result |
|---|---|---|---|
| Head of Clinical Coding | 2.0 (draft 1) | | |
| Chair, Mortality Monitoring Committee | 2.0 (draft 1) | | |
| Mortality Monitoring Committee | 2.0 (draft 2) | | |
| Corporate Medical Director – Patient Outcomes | 3.0 (draft 1) | 10/7/2017 | |
| Head of Clinical Coding, BIU and EPR | 3.0 (draft 2) | 14/7/2017 | Addition of EPR training responsibilities |
| Clinical Nurse Specialist - Learning Disabilities | | | Clarified position re: children with learning disabilities. Ensured correct role title. |
| Liaison Psychiatry lead | 3.0 (draft 2) | 14/7/2017 | Changed 'ensuring national requirements met' to 'contributing to learning from deaths'. |
| Patient Outcomes Lead – Maternity | 3.0 (draft 2) | 13/7/2017 | Changed 'still births and neonatal' to 'perinatal and infant' (6.16) |
| Mortality leads – neonatology and child health | 3.0 (draft 2) | 13/7/2017 | None required |
| Head of Patient Safety, Head of Complaints, Associate Director for Governance & Assurance, Corporate Medical Director – Patient Safety & Governance | 3.0 (draft 2) | 14/7/2017 | Complaints – none required.<br>Patient safety – minor changes. |
| Mortality Monitoring Committee | 3.0 (draft 3) | 19/7/2017 | Addition of flow chart. |
| Executive Quality Committee | 3.0 (final) | 31/07/2017 | |

## Reviews and updates

| Date | New version no. | Summary of Changes | Major change/s (must go to KE) or minor change/s | Author of change/s |
|---|---|---|---|---|
| 22/6/16 | 2.0 | Updated team names, minor editorial changes. | Major review (3 year review), minor changes | Claire Palmer, Head of Patient Outcomes |
| 05/07/2017 | 3.0 | Major review and update to take into account Learning from Deaths requirements, including e-death certification process and e-MRF, and the Trust Divisional restructure. | Major review and update | Claire Palmer, Head of Patient Outcomes |

## Dissemination schedule (after ratification)

| Target audience(s) | Method | Person responsible |
|---|---|---|
| Divisional management teams, Patient Outcomes Leads and Mortality Leads; membership of Mortality Monitoring Committee | Direct email | Head of Patient Outcomes |
| All trust staff | Intranet | Head of Patient Outcomes |

# Index

# 1. Introduction

1.1 Routine mortality monitoring underpins King's College Hospital NHS Foundation Trust (KCH) approach to patient outcomes monitoring and clinical quality improvement.

1.2 KCH seeks to develop and promote a culture of systematic mortality monitoring across the organisation by requiring Divisions to adopt a structured mortality review process in each of its Care Groups.

1.3 This policy describes KCH processes for reviewing patient deaths to support learning and development with the aim of identifying areas in which care and treatment can be improved and taking action to achieve improvement.

1.4 This policy sets out the approach that KCH takes to compliance with national requirements set out in Learning from Deaths.

# 2. Definitions

2.1 **Mortality:** patient death. Mortality review seeks to identify patient deaths which may have been preventable, to gain experience and learning from deaths that were unexpected and/or to identify any aspect of the care of an individual or group of patients that might be improved.

2.2 **Unexpected deaths** are the difference between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at KCH, within that specialty area.

2.3 **Morbidity:** patient illness. Morbidity review particularly seeks to identify preventable illness or illness where severity or symptoms might be reduced.

2.4 **Mortality lead:** the clinical lead for mortality reviews within Care Groups/specialties.

2.5 **Patient Outcomes Lead**: the clinical lead for all patient outcomes work at Care Group level.

2.6 **Neonatal death:** death which occurs within 28 days of birth.

2.7 **Summary Hospital-level Mortality Indicator (SHMI):** an indicator produced by NHS Digital (previously Health and Social Care Information Centre) to report mortality at trust-level across the NHS in England using a standard and transparent methodology.

2.8 **Hospital Standardised Mortality Ratio (HSMR):** an alternative indicator of mortality produced by Dr Foster Unit at Imperial College.

2.9 **HED:** an IT system that provides access to Hospital Episode Statistics data and enables analysis of mortality data including SHMI and HSMR. HED is available to all senior clinicians at KCH by request to the Patient Outcomes Team.

2.10 **Avoidable death:** a death is defined as avoidable where 'in the light of medical knowledge and technology available at the time of death, all or most deaths from this cause could be avoided through good quality healthcare…'(Office for National Statistics, 2015).

2.11 **Learning disability:** is defined as:

- A significantly reduced ability to understand new or complex information, to learn new skills (impairment of intelligence often measured by IQ)
- A reduced ability to cope independently (impaired social functioning)
- Started before adulthood (18 years) with a lasting effect on development (Department of Health, 2001).

2.12 **Severe mental illness:**

- Excludes:
  - People with dementia
  - People with learning disability (unless with a co-existing mental illness)
  - Children and adolescents.
- Includes people diagnosed with:
  - Mental and behavioural disorders due to psychoactive substance abuse
  - Schizophrenia, schizotypal and delusional disorders
  - Mood (affective) disorders
  - Neurotic, stress-related and somatoform disorders
  - Behavioural syndromes
  - Disorders of adult personality and behaviour.

# 3. Purpose and scope

3.1 This policy aims to ensure KCH has a systematic and consistent approach to:

- Undertaking mortality reviews within the different specialties across the Trust.
- Investigating mortality outliers.
- Reporting mortality information from specialty to Board.

3.2 This policy excludes:

- The death certification process.
- Duty of Candour.

# 4. Duties

4.1 **Discharging consultants** are responsible for:

- Ensuring accurate diagnoses are recorded on the patients' discharge summary.
- Ensuring the completion of accurate death certificates by providing supervision for doctors in training.
- For services with access to EPR, ensuring that doctors in training complete the EPR death certification process for all patients, and providing supervision to the doctors in training throughout the process as required.
- For consultants with access to EPR, ensuring that an EPR Mortality Review Form (MRF) is completed for patients in the required categories (see below). For consultants without access to EPR, ensuring that a paper MRF is completed and stored on a KCH shared drive.
- For consultants with access to EPR, reviewing the coding recorded during the final admission of any in-patient who died under their care at KCH, ***unless*** responsibility has been specifically designated to another clinician(s) by the Care Group/specialty, and Notifying the Head of Coding if the discharging consultant is incorrect.

4.2 **All consultants** are responsible for:

- Routinely and systematically reviewing patient deaths, with the aim of identifying any areas in which clinical, process and/or structural improvements can be made, and taking action to address these.
- Using the standard KCH Mortality Review Form (EPR or paper, see Appendix 1), to record the outcome of their mortality reviews, unless an exception has been approved by the Mortality Monitoring Committee (MMC).
- Recording quality issues identified during mortality reviews as adverse incidents, in accordance with the KCH Policy for the Management, Reporting and Investigation of Adverse Incident (including Serious Incidents).
- Attending Care Group Morbidity and Mortality Meetings to ensure peer review and learning from deaths.
- Participating in mortality investigations as requested by the Care Group Patient Outcomes Lead.

4.3 **Care Group Patient Outcomes Leads** are responsible for:

- Establishing and maintaining effective morbidity and mortality review processes within the Care Group and ensuring the participation of all consultants.
- Ensuring that a record is kept of attendance at morbidity and mortality meetings and the learning outcomes achieved.

- Ensuring that deaths of all patients in the required categories (see below) have a completed MRF, including the assessment of quality of care and avoidability of death.
- Ensuring reporting of mortality reviews and learning from deaths to the Divisional Management Team as required, including escalation of quality of care issues and issues relating to consultant engagement.
- Ensuring reporting of mortality reviews and learning from deaths to the Trust's Mortality Monitoring Committee (MMC) using the standardised presentation provided by the Patient Outcomes Team.
- Ensuring all quality issues identified during mortality reviews are recorded as adverse incidents, in accordance with the KCH Policy for the Management, Reporting and Investigation of Adverse Incident (including Serious Incidents).
- Participating in the investigation of any areas in which KCH is identified as an actual or potential mortality outlier, or at risk of being so, and leading on the development and implementation of action plans, in accordance with the KCH Mortality Outlier Alert Review Process (see Appendix 2).
- Care Group Patient Outcomes Leads may delegate all or part of the mortality monitoring aspect of their role to senior consultant Mortality Leads.

4.4 **Divisional Management Teams** are responsible for:

- Ensuring each Care Group/specialty participates in mortality review and reporting in accordance with the requirements of this Policy.
- Ensuring all consultants participate in morbidity and mortality review meetings.
- Ensuring participation of doctors in training in the morbidity and mortality review process as part of their training.
- Ensuring effective supervision of doctors in training in particular in relation to the completion of the death certification process.
- Ensuring the sharing of information to other Divisions as required.
- Ensuring the involvement of the entire multidisciplinary team as required.
- Implementing actions arising from mortality reviews as identified by the mortality leads, or providing a clear rationale for non-implementation.
- Escalating issues to the MMC as required.
- Taking action to improve the quality (completeness, accuracy and timeliness) of Trust data as required.
- Ensuring there are adequate resources in place, in particular clinical time, to enable systematic mortality review to be undertaken and improvements to be implemented as a result.

4.5 In addition to the responsibilities outlined above the **Divisional Management Teams responsible for Women's and Children's Services** are responsible for ensuring adherence to the specific requirements set out in this Policy for maternal and child deaths (see below).

4.6 The **Mortality Monitoring Committee (MMC)** is responsible for:

- Ensuring that any exceptions to this Policy are reviewed, approved and recorded in the MMC minutes.
- Systematically reviewing the following and identifying any areas in which clinical and/or process improvements can be made and taking action to address these:
    - Trust-level mortality data every month, including that relating to all the required categories (see below).
    - Mortality data for each specialty every 6 months, ***unless*** an exception has been approved by the MMC.
    - Divisional response rate to the coding verification process for in-patient deaths (for areas with access to EPR) every month.

- Receiving bi-annual reports from the KCH leads for learning disabilities and severe mental illness and identifying improvement actions as appropriate.
- Leading on the investigation of any areas in which KCH is identified as an actual or potential mortality outlier and monitoring the development and implementation of improvement action plans, in accordance with KCH Mortality Outlier Alert Review Process (see Appendix 2).
- Quarterly reporting, through the Patient Outcomes Report, of high-level mortality review performance, including performance in relation to the required categories (see below).
- Annual reporting, and escalating immediately any serious concerns relating to mortality, to the Patient Outcomes Committee (POC) and within the Trust's Quality Account as set out in national guidance.
- Working with Care Groups, Divisions and other Committees to develop the Trust's strategy in relation to mortality monitoring, including improving the recording of clinical information, coding, death certification, Divisions' mortality monitoring processes and the Trust's approach to address national and local requirements for mortality data and reporting.

4.7 The **Patient Outcomes Committee (POC)** is responsible for:

- Holding the MMC to account establishing and maintaining mortality monitoring structures and processes to enable the delivery of the Trust's responsibilities.
- Taking action through its membership to ensure adherence to this Policy.

4.8 The **Executive Quality Committee** is responsible for:

- Holding the Divisional management teams to account for ensuring full participation in the Trust's mortality monitoring processes, including taking action to improve patient outcomes and experience, completion of mortality reviews, MRFs, attendance at morbidity and mortality meetings, Care Group leadership of mortality review, attendance at MMC and delivery of required presentations, taking action to improve data.
- Ensuring that improvement actions required at organisational-level are taken.
- Ensuring Trust adherence to national requirements, including those of its regulators, in relation to mortality monitoring.

4.9 The **Corporate Medical Director – Patient Outcomes** is responsible for:

- Development of the Trust's strategy in relation to mortality monitoring.
- Reporting progress to the Executive Medical Director and executive committees as required.
- Developing training materials to support the mortality review process, including those parts of the process involving EPR.

4.10 The **Patient Outcomes Team** is responsible for:

- Developing and updating the Mortality Monitoring Policy.
- Supporting the MMC, including taking minutes, administering the action tracker and providing reporting templates as required.
- Presenting a summary of the Trust-level mortality data to the MMC every month.
- Providing details of in-patient deaths to Divisions/specialties as required.
- Ensuring MMC annual reporting is scheduled on the POC agenda.
- Escalating issues with the participation in, or implementation of recommendations from, mortality monitoring to the MMC as required.
- Developing training materials to support the mortality review process, including those parts of the process involving EPR.

4.11 The **Trust lead for Adult Safeguarding** is responsible for:

- Ensuring the national requirements for the review of deaths of people with learning disabilities are implemented at KCH, or escalating issues to the MMC.
- Reporting on learning from the review of deaths of people with learning disabilities to the MMC at least annually.

4.12 The **Trust Liaison Psychiatry lead** is responsible for:

- Contributing to the review and learning from the deaths of people with severe mental illness and reporting to the MMC at least annually.

4.13 The **Business Intelligence Unit (BIU)** is responsible for:

- Providing samples for Mortality Outlier Alerts (identified from internal and external sources) in accordance with the KCH Mortality Outlier Alert Review Process (see Appendix 2).
- Ensuring access to mortality data, e.g. through the HED system, for clinicians and the Patient Outcomes Team.

4.14 The **Coding Department** is responsible for:

- Managing a process of coding verification for in-patient deaths e.g. through the use of the Coding Management System in areas where the Electronic Patient Record (EPR) is in place, or coding review meetings with clinical teams.
- Presenting a summary of the Divisional response rate to the coding verification process for in-patient deaths to the MMC every month.

4.15 The **EPR team** is responsible for:

- The ongoing development of the e-death certification and eMRF forms and the delivery of the reports required by the MMC.
- Ensuring the e-death certification and eMRF processes are made available to all doctors at an early stage EPR roll-out to new EPR areas.

4.16 The **Patient Safety Team** is responsible for:

- Developing and providing access to a report of patient deaths where serious harm has been identified, e.g. through the Datix system, to the Patient Outcomes Team.
- Supporting serious incident reviews or adverse incident reviews which may stem from mortality/death reviews where care or service delivery issues are identified in line with the incident reporting policy (s 6.6) and national frameworks.

4.17 The **Complaints Team** is responsible for:

- Developing and providing access to a report of complaints received in relation to a patient death, e.g. through the Datix system, to the Patient Outcomes Team.

# 5. Deaths for which detailed mortality review is a requirement

5.1 KCH aims to undertake a detailed mortality review using the MRF for every death occurring in one of its hospitals.

5.2 Completion of a detailed mortality review using the Trust's Mortality Review Form (MRF) is always required for the following:

- Deaths identified (e.g. through the e-death certification or 'filtering' review) as avoidable, where quality of care may have been poor, or identified as requiring review at a senior level.
- Deaths of all patients with identified learning disabilities.

- Deaths of all patients with identified severe mental illness.
- Deaths where the patient was admitted as an elective admission.
- Deaths where an adverse incident indicates significant patient harm.
- Deaths where a complaint is received.

5.3 For specialties that have very high numbers of deaths e.g. gerontology, a 'filtering' review can be undertaken to exclude deaths that were clearly unavoidable and had no associated quality of care issues. For areas with access to EPR this will be undertaken through the e-death certification process (see below).

# 6. Process for systematic mortality review

6.1 For KCH services with access to EPR, a doctor, most often one in training, completes the e-death certification process at the same time as writing the death certificate (a guide for the e-death certification process is available on the intranet). This process must be supervised by the doctors' seniors.

6.2 For all KCH services a Mortality Review Form (MRF) is completed, usually by the discharging consultant, for all patients who have died, UNLESS an exception has been approved by the MMC. Exceptions may be approved, for example, for specialties with very high numbers of deaths such as gerontology, or where an alternative nationally-approved process is in place, such as maternal and child deaths. If the MRF is not utilised then it is expected that all cases will have, at a minimum, an overall assessment made of the degree of avoidability as per the MRF process.

6.3 MRFs are completed on EPR where clinicians have access to EPR. Where there is no EPR access a paper MRF is completed and stored on a KCH shared drive.

6.4 Completed MRFs form the basis of specialty morbidity and mortality meetings, with the aim of identifying specific actions and learning points that will contribute to improving patient care.

6.5 The Care Group Patient Outcomes Lead (or delegated Mortality Lead) compiles the findings from the completed MRFs (or alternatives, e.g. for maternal and child deaths), along with the actions and learning points from morbidity and mortality meetings, into:
- A standardised presentation to the MMC at the required frequency.
- A report for the Divisional Management Team, as required.

6.6 Individual clinicians report quality issues identified during mortality reviews as adverse incidents, in accordance with the KCH Policy for the Management, Reporting and Investigation of Adverse Incidents (including Serious Incidents).

**Specific cases: Maternal death reviews**

6.7 For maternal deaths, an internal mortality review results in findings documented into a formal report, which is then subject to external review by a Consultant Obstetrician and Consultant Midwife from Guy's and St Thomas' NHS Foundation Trust. This process is in accordance with best practice and the subject of an informal arrangement between the two Trusts.

6.8 A case review meeting attended by the Clinical Director for Women's Services, the mortality lead for Maternity, the KCH Patient Safety Manager for Maternity and the external reviewers is held to discuss the maternal death in detail and incorporate any additional comments and recommendations into a final report. The action plan is agreed as part of this process.

6.9 A debrief meeting is held following the review of a maternal death to which all maternity staff and representatives from any other relevant specialties are invited.

6.10 A case study of a maternal death and any resulting recommendations are presented at the monthly Risk Management Training for midwives.

6.11 A summary of the review findings will be presented to MMC at least annually.

6.12 The Divisional management team responsible for maternity services is responsible for ensuring that all maternal deaths are reported to KCH Commissioners, the CQC, the Local Supervising Authority (LSA) Midwifery Officer and the NHS London Commissioning Board in accordance with the KCH Policy for the Management, Reporting and Investigation of Adverse Incidents (including Serious Incidents).

6.13 Data on maternal deaths are reported directly to MBRRACE-UK in accordance with KCH Confidential Enquiry Policy.

**Specific cases: Reviews of the death of a child or young person**

6.14 The Divisional management team for children's services is responsible for ensuring that all deaths of a child or young person under 18 years (including neonatal deaths) at KCH are reported to the KCH Safeguarding Children's Team in accordance with the KCH Process for Reporting the Death of a Child or Young Person.

6.15 All relevant neonatal deaths are reported to the neonatal subgroup of the Child Death Overview Panel (CDOP), for the relevant London borough. All unexpected deaths or deaths with an identified, or potential, quality of care issue are escalated to the full CDOP. Reports are made to CDOP direct, in accordance with their protocols. A copy of the KCH neonatal discharge summary is also submitted.

**Specific cases: Reviews and reporting of perinatal and infant deaths**

6.16 Data on all perinatal and infant deaths are reported directly to MBRRACE-UK in accordance with KCH Confidential Enquiry Policy.

**Specific cases: Reviews of the death of a person with learning disabilities**

6.17 Deaths of any person with an identified learning disability must be notified to the Trust Clinical Nurse Specialist for Learning Disabilities. For services with EPR, an automated report is generated as part of the e-death certification process to enable cross-checking of reporting.

6.18 The KCH MRF is completed by the clinical team responsible for the patient.

6.19 The Trust Clinical Nurse Specialist for Learning Disabilities completes the requirements of the national Learning Disabilities Mortality Review Programme

(LeDeR), which will prompt a detailed review which may be undertaken by KCH staff or another agency at the direction of LeDeR.

6.20 A summary of the review findings will be presented to MMC at least annually.

6.21 Child death reviews are carried out through the usual child death review process, described above.

**Specific cases: Reviews of the death of a person with severe mental illness**

6.22 Deaths of any person with an identified severe mental illness must be notified to the Liaison Psychiatry team.

6.23 The KCH MRF is completed by the clinical team responsible for the patient.

6.24 The Liaison Psychiatry team will review the MRF and give consideration to whether additional improvement actions and/or learning from the death is required, and will report to the Care Group Patient Outcomes Lead.

6.25 A summary of the review findings will be presented to MMC at least annually.

# 7. Using national data

7.1 As well as data from specific mortality reviews, Patient Outcomes Leads have access to:

- Hospital Episode Statistics (HES) data from the Healthcare Evaluation Data (HED) system or from NHS Digital.
- National clinical audit data, including that from the Consultant Outcomes Publication.

7.2 These data sources are used by the Patient Outcomes Leads, the Corporate Medical Director – Patient Outcomes, the Patient Outcomes Team and the MMC to triangulate with local data and knowledge of clinical services and KCH casemix to draw conclusions about the quality of care of KCH patients.

# 8. Trust-level mortality monitoring

8.1 The Corporate Medical Director (Patient Outcomes) and the Patient Outcomes Team systematically review, at the Patient Outcomes Data Review Group, HES data (via NHS Digital and HED), all published national clinical audit and reports from the Consultant Outcomes Publication programme.

8.2 The Corporate Medical Director (Patient Outcomes) reviews both ward-level mortality data and deaths occurring in patients with an elective (planned) admission provided monthly by the Business Intelligence Unit.

8.3 Nationally-recognised mortality indicators (Summary Hospital-level Mortality Indicator [SHMI] and Hospital Summary Mortality Ratio [HSMR]) are reviewed at a Trust-level, hospital site-level and specialty-level at monthly MMC meetings. In addition SHMI for elective and non-elective, weekend and weekday admissions and high-risk

diagnostic groups, and Trust mortality compared to peer is reported at MMC.

8.4 All serious incidents where there has been harm leading to a patient's death will be reviewed in detail at the Serious Incident Committee as well as Care Group and Divisional quality governance meetings. Adverse incidents identified during the mortality review which may not have contributed to the death will also be reviewed at local governance meetings.

8.5 High-level summaries of serious incidents leading to a patient's death and any complaints made in relation to a patient's death, including actions taken and learning derived as a result of the investigation, will be presented to MMC as part of the relevant specialty's standard report, and the information triangulated with other mortality data from the specialty.

8.6 Key mortality indicators, including those outlined above and, in addition, mortality by gender, deprivation quintile and ethnic group, and those identified through national clinical audit, are included in the Trust patient outcomes indicators reported quarterly through the Patient Outcomes Report to the Patient Outcomes Committee, Executive Quality Committee, Quality Assurance and Research Committee, Trust Board and Commissioning Quality Review Group.

# 9. Mortality outlier identification and investigation

9.1 Occasionally, through routine review of mortality data as described above, through direct contact from an outside agency (e.g. CQC, medical royal college) or through any other method, mortality at KCH may be identified as being higher than expected. In this case, the KCH Mortality Outlier Alert Review Process (see Appendix 2) is followed.

9.2 Mortality outlier investigations are led by the Corporate Medical Director – Patient Outcomes and reported through the MMC.

# 10. Ensuring improvement and capturing learning from deaths

10.1 Most improvement actions will be agreed and implemented at the specialty- or Care Group-level. Multi-disciplinary and peer review, discussion and learning will take place in morbidity and mortality review meetings. Summary notes are recorded, stored on a KCH shared drive and shared with the MMC (a template for summary notes is available on the Trust intranet).

10.2 Care Groups will escalate the need for higher-level improvement actions to the Divisional Management Teams as required and report them to the MMC. Divisional management teams will raise actions required at a Trust-level through the Executive Quality Committee.

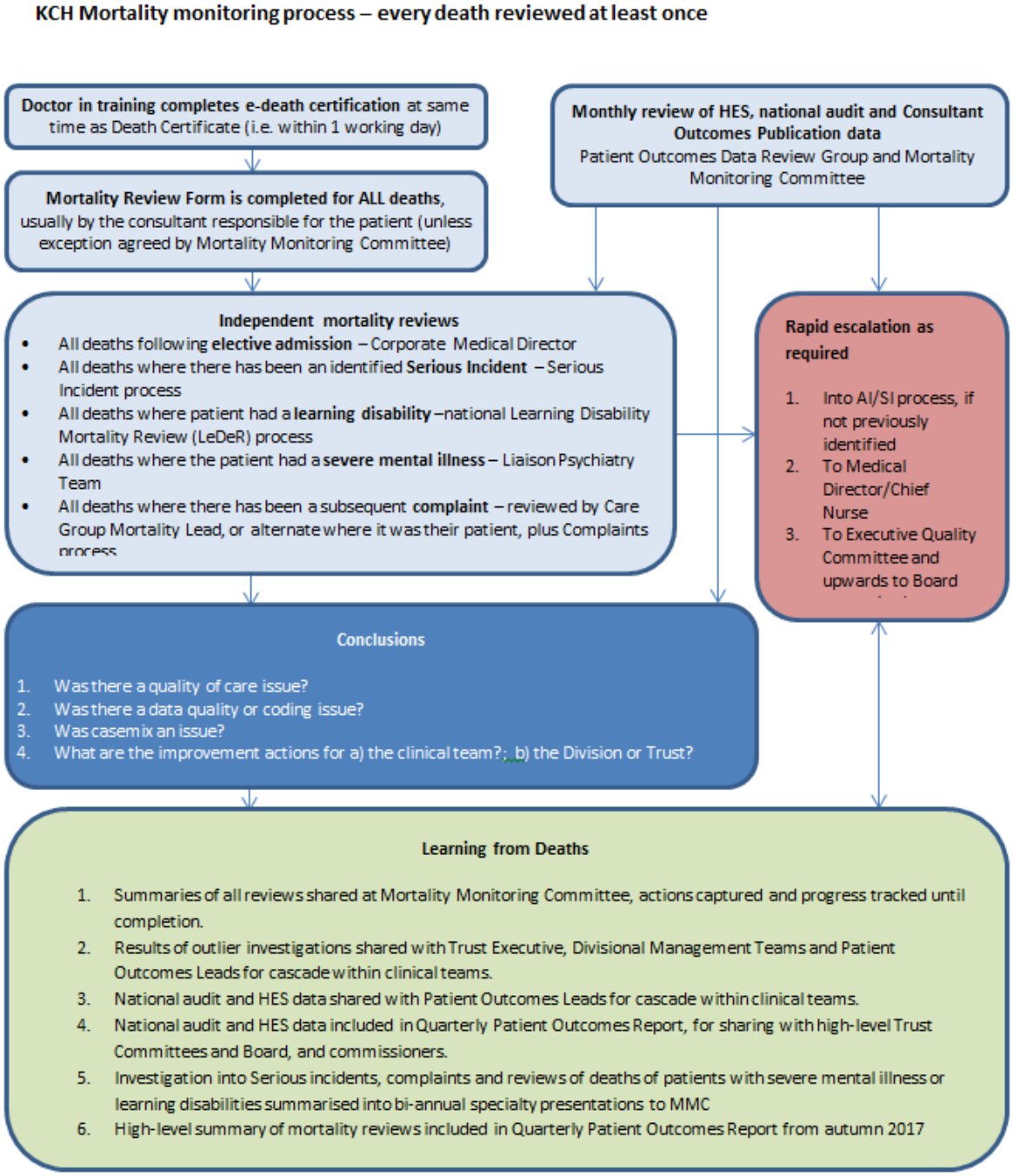
10.3 Divisional Management Teams will require Care Groups to make progress reports at agreed intervals.

10.4 The MMC has a monitoring role in ensuring that improvement actions are taken and that there is evidence of learning from deaths at specialty- and organisation-levels. This information will be captured and reported through the Patient Outcomes Report.

# 11. Summary of KCH Mortality Monitoring Process

11.1 The processes described above will ensure that every death at KCH is reviewed at least once. It is likely that some deaths are reviewed more than once, for example where patients are cared for in more than one specialty, e.g. major trauma and neurosurgery.

11.2 Summary of the KCH mortality monitoring process:



# 12. How KCH verifies the coding of in-patients who have died

12.1 Accurate coding is essential for mortality monitoring as it enables the provision of accurate data samples. It also feeds into routine mortality monitoring at Trust and national level.

12.2 Where EPR is available, the Coding Department provides the discharging consultant with the coding recorded during the final admission of any in-patient who died under their care at KCH, ***unless*** responsibility has been specifically designated to another clinician(s) by the Division/specialty.

12.3 The discharging consultant reviews the coding recorded during the final admission of any in-patient who died under their care at KCH, ***unless*** responsibility has been designated to another clinician(s) by the Division/specialty. The coding verification request must be responded to within 28 days of receipt.

12.4 The discharging consultant notifies the Head of Coding immediately if the discharging consultant has been recorded incorrectly.

12.5 The Head of Coding liaises with the Divisional management teams to correct the discharging consultant on PiMS as required.

12.6 The coding recorded during the final admission of any inpatient who died at KCH is reviewed by the mortality lead for the Division/specialty that the patient was assigned to at discharge, in conjunction with the Coding Department ***unless*** responsibility has been designated to another clinician(s) by the Division/specialty. The process is led by the Division/specialty as required.

12.7 The Coding Department presents a summary of the Divisional response rate to the coding verification process for in-patient deaths to the MMC every month.

12.8 The Coding Department provides Consultant level data detailing responders and non-responders for the coding verification process for in-patient deaths to Divisions/specialties as required.

# 13. Associated Documents

### Related Policies

- KCH Policy for the Management, Reporting and Investigation of Adverse Incidents (including Serious Incidents).
- KCH Process for Reporting the Death of a Child or Young Person.
- Being Open and Duty of Candour Policy.

### Supporting Documentation

Further information on mortality monitoring and learning from deaths can be found on the KCH intranet, including:

- Information and guide to EPR death certification
- Information on mortality monitoring, including a copy of the paper MRF and guides to using both EPR and paper MRFs.

# References

Department of Health (2001) *Valuing People - A New Strategy for Learning Disability for the 21st Century.*
Office for National Statistics (2015) *Statistical bulletin: Avoidable mortality in England and Wales: 2015*.

# Appendix 1: KCH Mortality Monitoring Form

The Mortality Monitoring Form is regularly reviewed and updated by the Mortality Monitoring Committee, therefore a copy has not been included in this Policy. The latest version can be retrieved here:
KCH Mortality Review Form (MRF).doc

# Appendix 2: KCH Mortality Outlier Alert Review Process

## Introduction

1.1 Mortality outlier alerts are generated when KCH performance is identified as worse than expected in relation to mortality rates.

1.2 This paper provides a summary of the process initiated once an alert has been received, to ensure a robust investigation takes place and improvement actions are taken as required.

## Definitions

2.1 **Mortality Outlier Alert:** a report on instances where the data indicate that the Trust's mortality rate has exceeded the national norm for one or more specific diagnosis or procedure codes. Alerts can be generated by:

- The Care Quality Commission (CQC).
- KCH Mortality Monitoring Committee (MMC) following review of internal or external data relating to KCH mortality.
- KCH Executive or executive-level committees.

2.2 **Mortality reviewer:** a clinician appointed by the Medical Director, MMC or Divisional management team to undertake the review of patient health records fundamental to the alert investigation.

2.3 **Casemix:** the classification of patients to provide a common basis for comparing cost effectiveness and quality of care across hospitals.

## The Mortality Outlier Alert review process

### Responding to CQC-generated alerts

3.1 The day the alert is received:

- The **Chief Executive** forwards the Alert to the Head of Patient Outcomes and the Medical Director.
- The **Head of Patient Outcomes** drafts a letter acknowledging receipt of the alert and agreeing the deadline for responding, as identified in the initial alert letter. The letter is sent to the CQC by the **Chief Executive**.
- Any difficulty identified responding to the CQC by the deadline set in the initial alert letter is communicated to the CQC lead by the **Head of Patient Outcomes** and a new deadline negotiated where possible.
- The **Head of Patient Outcomes** communicates with the CQC analysis team (or the Dr Foster Unit, where used by CQC) to request individual patient identifiers for each of the cases included in the Alert.

## Responding to all alerts

3.2 The day the alert is received:

- The **Head of Patient Outcomes** communicates the Alert to the appropriate Executives, Chair of the Mortality Monitoring Committee (MMC), Clinical Director/s and Divisional Manager/s and provides a detailed project plan with clearly outlined deadlines and key review questions.
- The appropriate **Clinical Director/s and Divisional Manager/s** nominate a minimum of two clinicians to be 'mortality reviewers' responsible for undertaking a review of the identified patient records.

## On receipt of individual patient identifiers

3.3 The **Head of Patient Outcomes** orders the appropriate patient records and coding details from the Head of Coding.

3.4 The **Head of Coding** provides the patient notes as requested and undertakes a review of coding and data accuracy in relation to the cases included in the alert.

3.5 The **Head of Patient Outcomes** forwards the list of patient identifiers to the Business Intelligence Unit (BIU) to obtain further patient details, including name, age, sex, diagnosis, specialty, admission method, consultant, admission date and discharge date.

3.6 The **BIU** provides the patient details requested.

3.7 The **Head of Patient Outcomes** forwards the list of patient identifiers to the Head of Patient Safety and Risk to identify whether there have been any adverse incidents reported in connection to the cases included in the Alert.

3.8 The **Head of Patient Safety and Risk** provides the information requested.

## Data analysis

3.9 Each **mortality reviewer** independently reviews a number of patient records in order to answer the following questions:

1. Is there any reason why the casemix of KCH and/or the sample would lead to an expected higher mortality than the national norm?
2. Has KCH coded the patients included in the sample in a way which may be different to other organisations' coding?
3. Are patient care issues the underlying reason for the outlier?

3.10 To improve inter-rater reliability and the overall quality of the results it is recommended that an additional reviewer reviews a minimum of one in five of the notes for quality assurance. It is, however, recognised that this is not always feasible within time and capacity restraints.

3.11 The **Patient Outcomes Team** organises a meeting attended by the Chair of the MMC, the 'mortality reviewers' and other key stakeholders to review the data analysis.

3.12 The **lead Division/specialty** ensures that all quality issues identified during review process are recorded as adverse incidents, in accordance with the KCH Policy for the Management, Reporting and Investigation of Adverse Incident (including Serious Incidents).

## The report

3.13 The **Head of Patient Outcomes** drafts a report, based on the results of the review of the patient records and the coding review and, where required, a response letter to the CQC.

- All patient and staff names are anonymised in the report and a key sheet kept in the Patient Outcomes Team.

3.14 The **Head of Patient Outcomes** circulates the draft letter of response to the CQC and the report to the Chair of the MMC, Medical Director, Director of Operations, Director of Nursing, appropriate Clinical Director/s, appropriate Divisional Manager/s, the mortality reviewers and the Assistant Director of Governance for review.

3.15 For CQC alerts, the final version of the response letter and report are sent by the **Chief Executive** to the CQC. The **Chief Executive** communicates the results of the review to KCH Executives and the Board of Directors.

3.16 The **Head of Patient Outcomes** forwards the report to the subsequent MMC meeting for discussion and action planning. Actions are summarised in the Patient Outcomes Report to the Quality & Governance Committee.

## Developing and implementing an action plan

3.17 The **Division/specialty** leads on the development and implementation of the action plan arising from mortality outlier alert reviews.

3.18 The **Divisional Quality Governance Committee** implements actions arising from mortality outlier alert reviews, or provides a clear rational for non-implementation.

3.19 The **MMC** monitors the implementation of action plans through the Committee's action tracker and reports annually, and escalates immediately any serious concerns arising from a mortality outlier alert review, to the Patient Outcomes Committee.

3.20 The **Patient Outcomes Committee** takes action through its membership to ensure full implementation of recommendations arising from a mortality outlier alert review, or provide a clear rationale for non-participation.

# Appendix 3: Checklist for the review and approval of Trust-wide policies

| | Requirements | Yes/no/ Unsure/Not applicable | Comments |
|---|---|---|---|
| **1.** | **Style and format:** | | |
| | Is the trust logo correct? | Yes | |
| | Does the policy follow KCH corporate identity guidelines, i.e. language concise and clear, is text in Frutiger, Tahoma or Arial and at least 12pt font, are pages numbered? | Yes | |
| **2.** | **Information on Front Cover** | | |
| | Are all of the following details present:<br>▪ Version and version date<br>▪ Ratified by and date ratified<br>▪ Author/s (name and job title)<br>▪ Responsible director<br>▪ Responsible committee<br>▪ Date policy comes into effect<br>▪ Review date<br>▪ Target audience<br>▪ Location of document | Yes | |
| **3.** | **Document history:** | | |
| | Is it clear what, if any, document this policy replaces? | Yes | |
| | Has the policy been consulted upon? | Yes | |
| | Is there a dissemination schedule? | Yes | |
| **4.** | **Definitions:** | | |
| | Are all unclear terms defined? | Yes | |
| **5.** | **Purpose and scope:** | | |
| | Is there a clear aim including the justification for the policy and how it links with trust priorities? | Yes | |
| | Is the scope of the policy clear (what is included & excluded)? | Yes | |

| | Requirements | Yes/no/ Unsure/Not applicable | Comments |
|---|---|---|---|
| **6.** | **Duties** | | |
| | Are duties included? | Yes | |
| **7.** | **Policy specific information: minimum requirements** | | |
| | As a minimum does the policy address the appropriate NHSLA Risk Management Standards at Level 1 where relevant? | Yes | |
| **8.** | **Review date** | | |
| | Has the review date been made explicit? | Yes | |
| **9.** | **Control of documents, including archiving arrangements** | | |
| | Is it described in the document where it will be held/stored? | Yes | |
| | Have the archive details of any superseded document been described in the document? | Yes | |
| **10.** | **Implementation:** | | |
| | Is implementation described, including any training and /or support implications? | Yes | |
| **11.** | **Process for monitoring compliance** | | |
| | Is it clear how compliance with the policy will be monitored? | Yes | |
| **12.** | **Associated documents** | | |
| | Are associated KCH documents listed? | Yes | |
| **13.** | **References** | | |
| | Are supporting references listed? | Yes | |
| **14.** | **Equality Impact Assessment:** | | |
| | Is an equality impact assessment included? | Yes | |

# Appendix 4: Equality impact assessment

*A screening equality impact assessment form and a full assessment form are available at* http://kweb/kwiki/Equality_and_diversity.

| **Service/Function/Policy** | **Directorate / Department** | **Assessor(s)** | **New or Existing Service or Policy?** | **Date of Assessment** |
|---|---|---|---|---|
| Mortality Monitoring Policy | Executive Nursing | Claire Palmer, Head of Patient Outcomes | Existing Policy | 10/07/2017 |

**1.1 Who is responsible for this service / function / policy?** Mortality Monitoring Committee

**1.2 Describe the purpose of the service / function / policy?** Who is it intended to benefit? What are the intended outcomes?
The aim of this document is to ensure that KCH has a comprehensive and consistent approach to mortality monitoring.

**1.3 Are there any associated objectives?** E.g. National Service Frameworks, National Targets, Legislation

**1.4 What factors contribute or detract from achieving intended outcomes?**
Successful implementation and compliance with the policy

**1.5 Does the service / policy / function / have an impact in terms of race, disability, gender, sexual orientation, age and religion?** Details: [see Screening Assessment Guidance]
A positive impact on all groups through improvement of services and patient care.

**1.6 If yes, please describe current or planned activities to address the impact.**
n/a

**1.7 Is there any scope for new measures which would promote equality?**
No

**1.8 Equality Impact Rating** [low, medium, high*]:
Low for all

**Race** ☐ **Age** ☐ **Disability** ☐ **Gender** ☐ **Religion** ☐ **Sexual Orientation** ☐

***If you have rated the policy, service or function as having a high impact for any of these equality dimensions, it is necessary to carry out a detailed assessment and then complete section 2 of this form***

**1.9 Date for next review** 10/07/2020