University Hospitals Bristol NHS
NHS Foundation Trust

Mortality and Morbidity Policy

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Document Abstract

This policy defines how divisions should manage their reviews of Mortality and Morbidity which are an essential part of clinical governance. The purpose of these reviews is to consider individual cases and trends, to identify and embrace opportunities for learning from experience and secure improvements in the quality of care provided. An absolute requirement is to identify changes in practice that would, in the future, prevent a death or reduce morbidity.

This policy defines minimum expectations of all divisions but allows for individual application in respect of different needs e.g. variations in numbers of deaths, different clinical governance structures and arrangements.

There is a separate, well established Child Death Review Process which is to be followed for all child deaths including adolescents aged 16 or 17 years.

[1] Divide number of words (2920) by 240 for average reading time and add 25% for specialist content.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
04 March 2003	N/A	Medical Director	New Policy	Approved
April 2011	1.3	Patient Safety Managers for the Divisions of Women and Children and Surgery	Updated morbidity policy	Draft
September 2014	2.0	Head of Quality (Patient Safety)	Updated Mortality and Morbidity Policy	Major update to include process for adult mortality reviews, routine surveillance of quality intelligence data relating to mortality and morbidity and strengthened governance arrangements for reviews of mortality and morbidity.
December 2015	2.1	Head of Quality (Patient Safety)	Minor	Minor amendment to section 5.2 to reflect agreement at Clinical Quality Group to receive adult and child mortality reports at least annually. Approved by Clinical Quality Group 03/12/2015.

Do I need to read this policy?

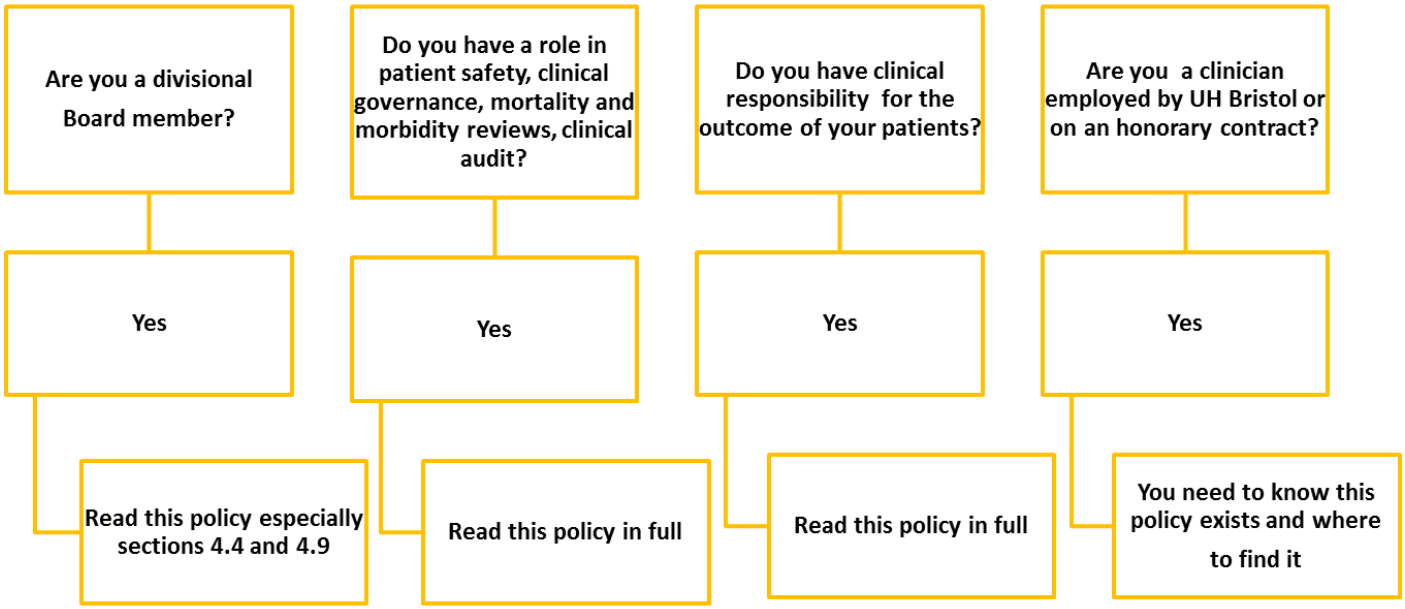


Table of Contents

1. Introduction

1.1 Mortality and morbidity reviews are an established part of the provision of high quality clinical care. The Trust Board regards mortality and morbidity reviews to be an essential element in clinical governance, and a key practice in the drive towards quality improvement.

1.2 Mortality and morbidity reviews are mandatory and the results of the reviews should be available for scrutiny.

1.3 It is principally the responsibility of consultant medical staff to conduct mortality and morbidity reviews for their specialities; this should be supported by the divisional management team.

1.4 Mechanisms for mortality and morbidity reviews should be robust and effective to identify learning from patient care episodes and to identify changes in practice that would, in the future, prevent a death or reduce morbidity.

1.5 The expectation is that mortality and morbidity data will be reviewed as a matter of routine and learning shared within the specialty and the division.

1.6 Cross divisional learning will be shared though upward thematic reporting of the outcomes of mortality and morbidity reviews.

1.7 Any incidents identified from mortality and morbidity reviews should be reported in line with the Trust's Policy for the Management of Incidents

1.8 Any risks identified from mortality and morbidity reviews should be risk assessed in line with Trust's Risk Assessment Standard Operating Procedure and entered on the departmental or divisional risk register.

2. Purpose and Scope

The aim of this policy is to set out clear roles and responsibilities for staff involved in mortality and morbidity reviews and to ensure as a Trust our obligations for learning and continuous improvement are being met, namely that:

2.1 Clinicians (doctors, nurses, allied health professionals) systematically use mortality and morbidity reviews to provide assurance that their service is safe, to share learning and to improve patient outcomes.

2.2 Results of mortality and morbidity reviews provide assurance that the Trust is doing all it can to learn from episodes of care where death has occurred.

2.3 This policy covers adult mortality reviews and morbidity reviews for adults and children. There is a separate, well established Child Death Review Process which is to be followed for all child deaths including adolescents aged 16 or 17 years.

2.4 There is also a separate policy which describes the Trust's processes for managing National Confidential Enquiries some of which could relate to mortality studies for specific groups of patients e.g. the national Confidential Enquiry into Maternal Deaths

2.5 This policy applies to all bed holding divisions and those which carry out day case interventional procedures.

3. Definitions

The following definitions are use in this policy:

3.1 Mortality

(a) In-hospital deaths in patients under the care of a defined consultant

3.2 Morbidity

(a) Complications that occur causing the patient to need further intervention or prolonged stay in hospital. Categories could include:

(i) Specifically defined morbidities i.e. predefined complications

(ii) Incidents or misadventures causing morbidities

(iii) Any other unexpected morbidity, based on clinical judgement

3.3 Clinician

(a) Any accountable clinical healthcare professional

4. Duties, Roles and Responsibilities

4.1 Trust Board of Directors

(a) The Trust Board of Directors has a duty to be satisfied that the Trust's arrangements for systematic review of mortality and morbidity are sufficiently robust to contribute to providing assurance that our services are safe, that learning from mortality and morbidity reviews is identified and shared to improve patient outcomes.

4.2 Medical Director

(a) The Medical Director is the lead executive director for mortality and morbidity.

(b) They are responsible for ensuring the Trust's arrangements for systematic review of mortality and morbidity are sufficiently robust to contribute to providing assurance that our services are safe, that learning from mortality and morbidity reviews is identified and shared to improve patient outcomes.

(c) They are responsible for ensuring systems for routine surveillance of quality intelligence data relating to mortality and morbidity are robust and any potential areas of concern are appropriately investigated and reported via the Trust Quality Intelligence Group.

4.3 Associate Medical Director for Patient Safety

(a) The Associate Medical Director for Patient Safety is responsible for identifying and implementing a robust process for systematic review of adult mortality and to report thematic learning to the Clinical Quality Group as shown in Appendix D.

4.4 Clinical Chairs and Divisional Directors

Clinical Chairs and Divisional Directors are responsible for:

(a) Ensuring arrangements for mortality and morbidity reviews within their division meet the requirements of this policy and are sufficiently robust to contribute to providing assurance that their services are safe, that learning from mortality and morbidity reviews is identified and shared to improve patient outcomes.

(b) Designating consultant leads for mortality and morbidity reviews for the division or sub-specialties

(c) Ensuring that systematic adult mortality reviews are carried out within the division as per the process set out in this policy

(d) Publishing on the Trust's intranet their local structure for Mortality and Morbidity Meetings e.g. divisional or sub-specialty level, frequency of meetings, names of designated consultant leads for mortality and morbidity

(e) Ensuring any incidents identified from mortality and morbidity reviews are reported in line with the Trust's Policy for the Management of Incidents

(f) Ensuring any risks identified from mortality and morbidity reviews are risk assessed in line with Trust's Risk Assessment Standard Operating Procedure and entered on the departmental or divisional risk register and escalated in accordance with the Trust Risk Management Policy if of sufficient magnitude.

(g) Monitoring the effectiveness of these arrangements within the division

4.5 Designated consultant leads for mortality and morbidity reviews

Designated consultant leads are responsible for:

(a) Ensuring mortality and morbidity reviews are carried out within the division/sub-specialty that meet the requirements of this policy and are sufficiently robust to contribute to providing assurance that our services are safe, that learning from mortality and morbidity reviews is identified and shared to improve patient outcomes.

(b) Chairing Mortality and Morbidity Meetings for the division/sub-specialty and that these meetings are conducted in line with the generic Terms of Reference in Appendix E. These meetings must be minuted and outcomes reported into the relevant divisional governance group and thematic learning and identified risks reported upward to the divisional Board.

(c) Ensuring outcomes of individual case reviews are documented using the template in Appendix F

(d) Producing reports from reviews of mortality and morbidity for the Divisional Governance Group

4.6 Mortality and Morbidity meetings

(a) Duties and responsibilities are set out in generic terms of reference in Appendix E and in section 5.3 of this policy.

4.7 Clinical Quality Group

The Clinical Quality Group is responsible for:

(a) Receiving assurance reports on outcomes and learning from systematic adult mortality reviews and the Child Death Review process.

(b) Receiving reports relating to mortality and morbidity from its sub-groups as shown in Appendix D.

(c) Identifying any new trust wide risks arising from thematic reporting of mortality and morbidity reviews and escalate to the Senior Leadership Team if of sufficient magnitude in line with the Trust's Risk Management Policy

4.8 Quality and Outcomes Committee

The Quality and Outcomes Committee is responsible for:

(a) On behalf of the Trust Board, receiving summary assurance reports on the outputs from mortality and morbidity monitoring within the Trust

(b) Appraising the Board of any concerns regarding mortality or morbidity identified from the information received

4.9 Divisional Management Boards

Divisional Management Boards are responsible for:

(a) Supporting the designated lead consultant(s) for mortality and morbidity reviews for the division or sub-specialties by ensuring this responsibility is reflected in job plans and to ensure administrative support is available for Mortality and Morbidity meetings.

(b) Ensuring there is provision for storage of anonymised information relating to mortality and morbidity reviews within their division on the Trust's intranet e.g. minutes and papers of Mortality and Morbidity Meetings

(c) Publishing evidence internally to provide assurance that lessons are being learned such as policies and training programmes, and preventative measures are effective

4.10 Divisional Governance Groups

Divisional Governance Groups are responsible for:

(a) Receiving reports of mortality and morbidity review outcomes, and ensuring learning is shared appropriately within the division and systemic changes in practice are implemented if required

(b) Considering future audit requirements for changes in practice and feed these into the division's clinical audit plan

(c) Identifying and reporting any new incidents or risks arising from mortality and morbidity review outcomes within the division

4.11 All clinicians

(a) All clinicians should participate in mortality and morbidity reviews as part of their clinical practice. This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

(b) Participation should take the form of open and transparent review of individual cases in the spirit of learning and continuous improvement.

(c) Clinicians should review, and adjust if appropriate, their personal and team clinical practice in response to learning from such reviews.

(d) Clinicians who attend Mortality and Morbidity Meetings should:

(i) contribute their knowledge and experience to those meetings

(ii) openly look for prevention strategies, without resorting to blaming others

(iii) help colleagues to deliver safer care on the basis of what has been learned, by building safeguards into existing practice and challenging practice that has been demonstrated to be unsafe

(iv) look to improve and standardise care for patients and their families

5. Policy Statement and Provisions

5.1 Policy statement

(a) It is the Trust's policy to take every opportunity to learn from ongoing and systematic review of the quality of its services from a range of sources, and to implement changes, either locally or systematically for continuous improvement. Mortality and Morbidity Reviews are one such source and should be robust and effective to identify learning from patient care episodes and to identify changes in practice that would, in the future, prevent a death or reduce morbidity.

(b) In specialties, teams that provide direct care to patients must be sufficiently involved in morbidity reviews so as to enable staff to understand what the underlying causes for morbidity are for patients in their care.

(c) The overarching reporting of mortality and morbidity is shown in Appendix D

5.2 Systemic Mortality Reviews

(a) A systematic on-going review of all adult deaths, excluding those patients which are receiving palliative care, will inform systematic and local learning from adult deaths

(b) The lead for this systematic review is the Associate Medical Director for Patient Safety

(c) The process for conducting the review is described in Appendix G

(d) The reporting of systemic mortality reviews monitoring is at least annually to the Clinical Quality group and upward to the Senior Leadership Team and Quality and Outcomes Committee and Trust Board as shown diagrammatically at Appendix D.

5.3 Mortality and Morbidity Meetings

(a) These should occur within all divisions/sub-specialties at a frequency to be determined by the division relative to different needs e.g. variations in numbers of deaths, different clinical governance arrangements

(b) These should be chaired by the designated consultant lead for the relevant Mortality and Morbidity Review

(c) Each Mortality and Morbidity Meeting will have terms of reference with content which is consistent with the template at Appendix E

(d) Cases to be reviewed at Mortality and Morbidity Meetings should, at a minimum, include:

(i) All deaths that are likely to involve a coroner's inquest

(ii) All cases where the Medical Director's/Chief Nurse's review of a potential serious incident has resulted in a request for review of the case at a Mortality and Morbidity Meeting

(iii) Cases from the on-going systematic mortality reviews where complications/misadventures have arisen or learning, either notable practice or otherwise, has been identified

(iv) Cases where complications/misadventures have occurred. If complications relate to the nature of high volume procedures this could take the form of a thematic review e.g. all cases of shoulder dystocia in obstetrics

(e) Other sources of information which could assist with mortality and morbidity reviews include:

(i) Relevant patient safety incident reports

(ii) Outcomes of Root Cause Analysis investigations

(iii) Pathology/post mortem reports

(iv) Quality intelligence data for the procedure/sub-specialty from the Trust's CHKS quality surveillance system with benchmarking data

(v) Literature reviews of the most recent outcomes/complication rates of a relevant procedure or treatment

(vi) National or local clinical audit outcomes

(vii) Data from other clinical systems which could inform the review

(viii) Complaints or concerns raised by the patient/family about the clinical care of the patient relating to the hospital admission

(f) Each Mortality and Morbidity Meeting will be minuted and outcomes reported into the relevant divisional governance group and thematic learning of identified risks reported upward to the divisional Board.

(g) The outcomes of individual case reviews should be documented using the template in Appendix F.

(h) Each Mortality and Morbidity Meeting will have a workspace whose content will include the minutes of the meetings, reports and learning from

(i) Any incidents identified from Mortality and Morbidity Reviews should be reported in line with the Trust's Policy for the Management of Incidents.

(j) Any risks identified from Mortality and Morbidity Reviews should be risk assessed in line with Trust's Risk Assessment Standard Operating Procedure and entered on the departmental or divisional risk register.

(k) Reporting the outcomes of Mortality and Morbidity Meetings will occur as follows:

(i) Within divisions to Divisional Governance Groups with thematic learning and identified risks reported upwards to the Divisional Board.

(ii) Organisation wide reporting as shown in Appendix D

6. Standards and Key Performance Indicators

6.1 Applicable Standards

(a) Mortality and Morbidity Meetings will take place in all bed holding divisions and those which carry out day case interventional procedures.

(b) Divisions will determine whether these take place at divisional or sub-specialty level and the frequency and will make this transparent by publishing this information on the Trust's intranet.

(c) Mortality and Morbidity Meetings will be minuted and outcomes included in reports provided to Divisional Governance Groups

(d) Learning from Mortality and Morbidity Reviews and associated changes in clinical practice will be apparent from the reports from Divisional Governance Groups to Divisional Boards

6.2 Measurement and Key Performance Indicators

(a) Divisional arrangements for Morbidity and Mortality reviews will encompass all in-patient and day interventional services provided.

(b) The above standards will be monitored via an annual audit

7. Associated Documentation

7.1 Policy for the Management of Incidents

7.2 Risk Assessment Standard Operating Procedure

7.3 Risk Management Policy

7.4 Clinical Audit Policy

7.5 Policy for the Participation in National Confidential Enquiries

7.6 Serious Incident Policy

7.7 Child Death Review Process

7.8 Flowchart process for learning from child death

8. Appendix A – Monitoring Table for this Policy

8.1 This policy will be monitored via a two yearly audit against the standards in section 6.

8.2 The outcome of the audit will be reported into the Clinical Quality Group

9. Appendix B – Dissemination, Implementation and Training Plan

9.1 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	[redacted]
This document replaces existing documentation:	Not Applicable
Existing documentation will be replace by:	Not applicable
This document is to be disseminated to:	Executive Directors, Divisional Boards and the Trust Patient Safety Group
Training is required:	Not Applicable
The Training Lead is:	Not applicable

Additional Comments
[DITP - Additional Comments]

10. Appendix C – Document Checklist

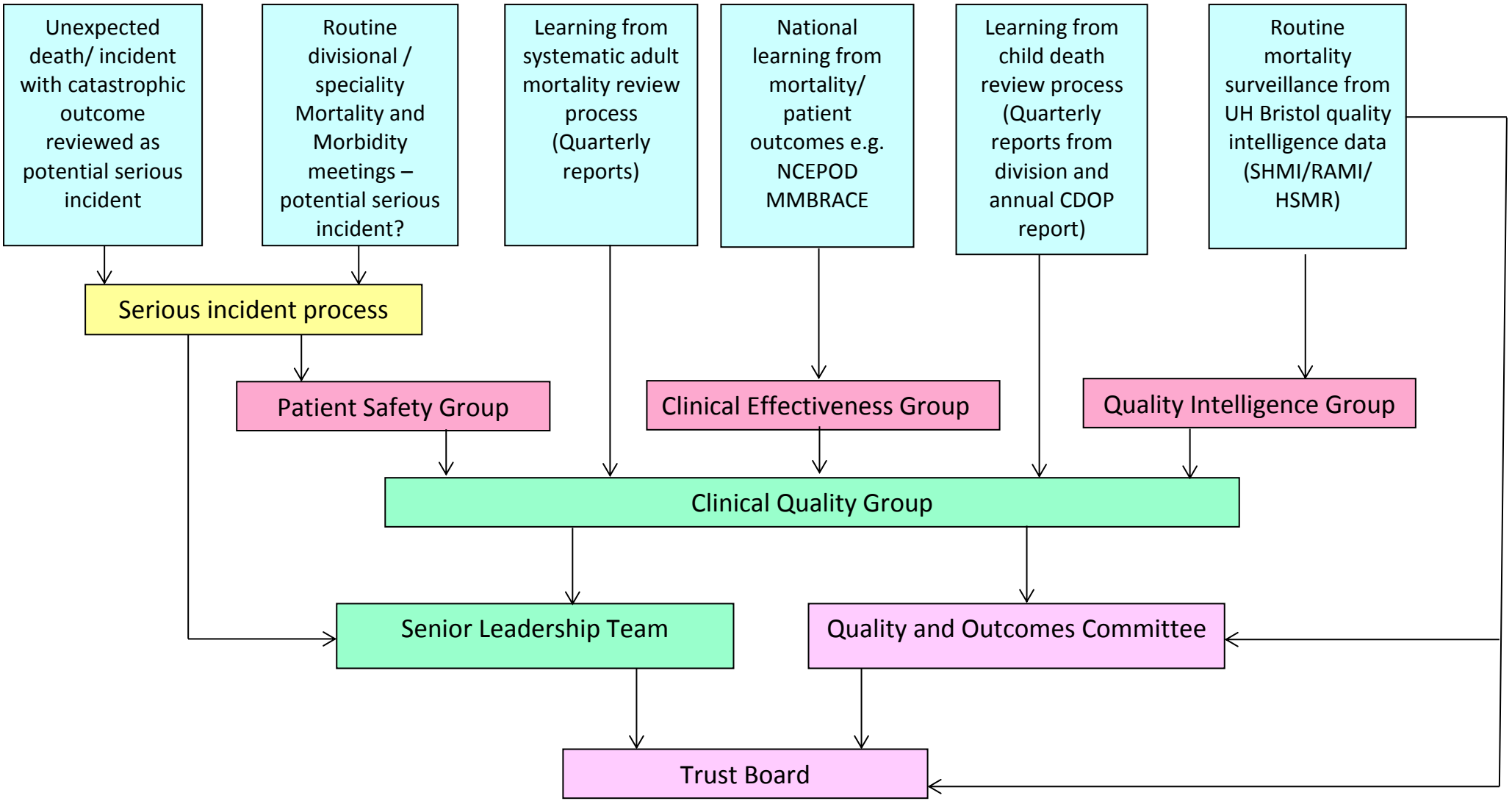
10.1 The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.):	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000):	Not Applicable
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Yes
	The following were consulted:	Divisional Boards, Patient Safety Group, Chief Nurse, Medical Director
	Suitable 'expert advice' has been sought where necessary:	Yes
Evidence Base	References are cited:	Not Applicable
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	Patients will be kept safe from avoidable harm
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	Not Applicable
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance with the	Yes

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
	provisions set out in this procedural document:	
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

Additional Comments
[DCL - Additional Comments]

11. Appendix D -Mortality Monitoring in UH Bristol



12. Appendix E-Generic Terms of Reference for Mortality and Morbidity meetings

12.1 Purpose of the Meeting

(a) To review mortality and morbidity, with the aim to:

(i) Identify any modifiable factors that might have made a difference to the outcome

(ii) Identify and disseminate lessons learnt following morbidity reviews

12.2 Membership (including a quorum)

(a) The morbidity review meeting is a multiprofessional meeting for all grades of clinical staff working within clinical services. The membership includes:

(i) Consultant medical staff

(ii) Patient safety managers/leads

(iii) Matrons

(iv) Nursing staff

(v) Junior medical staff

(vi) Student doctors, nurses and midwives

(b) The quorum shall be the designated consultant lead for mortality and morbidity within the division or sub-speciality and at least two other clinicians from the sub-speciality

12.3 Frequency of meetings

(a) To be determined by the division or sub-speciality but must occur at least quarterly

12.4 Format of the meeting

(a) Agenda will be distributed at least a week prior to the meeting

(b) The action plan from the previous Mortality and Morbidity Meeting will be reviewed at the start of the meeting and progress updates discussed

(c) Cases to be reviewed at Mortality and Morbidity Meetings should, at a minimum, include:

(i) All deaths that are likely to involve a coroner's inquest

(ii) All cases where the Medical Director's/Chief Nurse's review of a potential serious incident has resulted in a request for review of the case at a Mortality and Morbidity Meeting

(iii) Cases from the on-going systematic mortality reviews where complications/misadventures have arisen or learning, either notable practice or otherwise, has been identified

(iv) Cases where complications/misadventures have occurred. If complications relate to the nature of a high volume procedures this could take the form of a thematic review e.g. all cases of shoulder dystocia in obstetrics

12.5 Scope and duties

(a) To review mortality and morbidity with the aim to:

(i) Identify any modifiable factors that might have made a difference to the outcome

(ii) Provide educational opportunities for clinical staff

(iii) Identify and disseminate good practice and lessons learned

(iv) To agree action points

(v) To monitor action plans

(vi) To highlight topics for clinical audit

(b) Clinicians who attend Mortality and Morbidity Meetings should:

(i) contribute their knowledge and experience to those meetings

(ii) openly look for prevention strategies, without resorting to blaming others

(iii) help colleagues to deliver safer care on the basis of what has been learned, by building safeguards into existing practice and challenging practice that has been demonstrated to be unsafe

(iv) look to improve and standardise care for patients and their families

12.6 Authority to act

(a) The morbidity review committee is authorised by the Divisional Board to carry out its duties as set out above.

(b) To bring to the attention of the Divisional Board and Clinical Quality Group any risks where local mitigating action cannot reduce the clinical risk to an acceptable level and recommend additional action for approval

12.7 Reporting and communication structure

(a) Within divisions reporting of the outcomes of divisional mortality and morbidity reviews is to the divisional governance groups with thematic learning and identified risks reported upwards to the divisional Board.

13. Appendix F- Template for recording the outcome of reviews of individual cases at Mortality and Morbidity meetings

University Hospitals Bristol NHS
NHS Foundation Trust

Mortality/ Morbidity Review Form

CONFIDENTIAL

Age: _ _ _ _ _ years Gender: ❒ Male ❒ Female

Discussed at multidisciplinary meeting prior to procedure? ❒ No ❒ Yes

Operative Priority: ❒ Elective ❒ Urgent ❒Emergency

Meeting Date: _ _/_ _/_ _ _ _

Diagnosis & Procedure (If inoperable please state why)	
Pre-procedure Complications (Write 'NIL' if none)	
Post-procedure Complications (Write 'NIL' if none)	
Cause of Death as per death certificate	

Post mortem	❒	No	❒	Yes
Patient Safety Incident	❒	No	❒	Yes
Root cause analysis	❒	No	❒	Yes

Complaint ❒ No ❒ Yes

CONFIDENTIAL

Modifiable factors

❒ No care management problems/factors
❒ Care management problems/factors unlikely to have contributed to death
❒ Care management problems/factors identified may have contributed to vulnerability or death
❒ Care management problems/factors provide a complete and sufficient explanation of the death

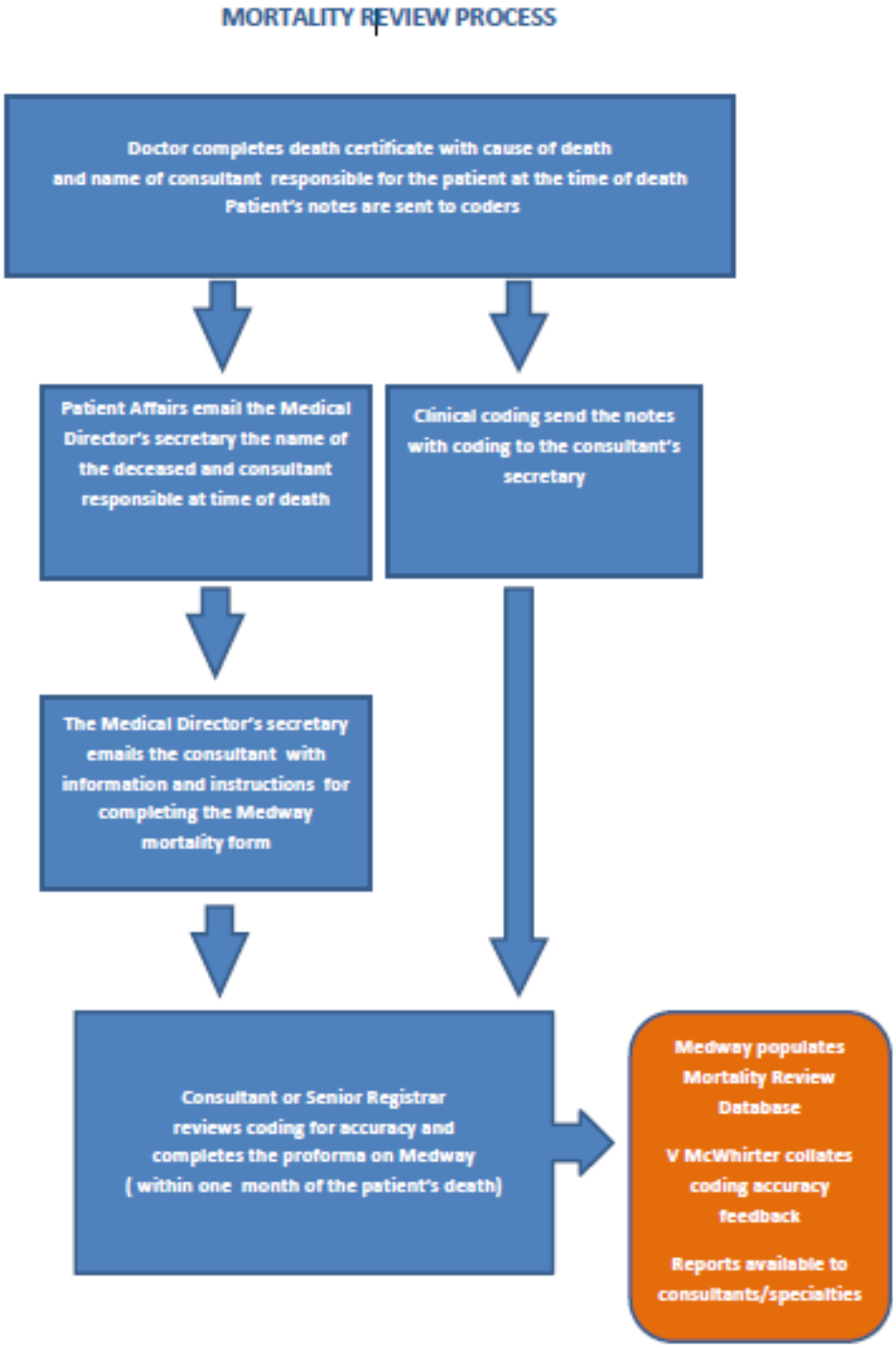
List modifiable factors/care management problems	
Notable practice	

Completed by: _ (print name)

_ (signature)

_ (date)

14. Appendix G- Process for conducting systematic adult mortality reviews



UH Bristol Adult Mortality Review – Launch May 2014

Background

This review is a method of collecting data for all adult patient deaths that have occurred in UHBristol. About 1500 adult deaths occur per year in the Trust.

Participating in this review enables us to collect data about mortality that includes;

Basic demographic data

- Cause of death
- If death was due to advanced progressive disease
- Comorbidities
- Named consultant, ward, speciality

Quality of care given

- Documentation of timely recognition of clinical deterioration
- Documentation of discussions with patients and family
- Use of advanced end of life care pathway/ treatment escalation plan

Identification of patterns of modifiable features

- Avoidable admissions - Could community services have prevented admission in palliative care?
- Identification of patterns of iatrogenic events both prior to and during admission – did problems in care potentially contribute to death?
- Any learning points identified in the notes review

The process

- The Patient Affairs Department will identify the correct consultant responsible for the patient's care at the time of death,
- The doctor completing the death certificate will be prompted to record

A) Cause of death documented on the death certificate in the notes

B) The correct consultant responsible for the patient at the time of death

C) If and who they have discussed what to document as the cause of death with a senior member of the team/coroner.

D) If they had any concerns about the circumstances of the death and who they have discussed this with

- Patient affairs will send an email to Medical Director's secretary notifying the name of the deceased and consultant responsible for care at time of death.

- The notes will be sent to the clinical coding department, and from there will be sent to the correct consultant's secretary (including a copy of the coding).
- An email will be sent from the Medical Director's secretary to the consultant with a copy of this document and instructions as to how to access the mortality form on Medway
- Consultant or senior registrar to complete the proforma on Medway within a month of the patient's death. Any questions – direct to Emma Redfern. Opportunity to review coding for accuracy.
- Database to be kept by Medical Director team to monitor progress of completion

(In the case of a patient being referred to the Coroner – the notes may not be available –the form may still be completed without the notes - e.g. patient died in ED after cardiac arrest)

Notes sent to Patient Affairs after ADULT patient death- death certificate completed by medical member of team

Cause of death to be documented in the notes and consultant responsible for care at the time of death – by medical member of team

Notes sent to coding

Email sent by patient affairs to Medical Directors secretary – notifying patients name and T number and consultant responsible for patient at time of death

Coding completed – notes sent to consultant

Email sent to consultant by MD secretary – include this document and document on 'how to access mortality review form on Medway'

Consultant receives notes and email and either consultant or senior SpR completes mortality review within one month of death

Opportunity to review discharge coding – any feedback about accuracy to Clinical Coding Manager

Outputs

Each consultant will be able to obtain reports for the mortality forms completed for patients who have died in their care. Similarly each ward/division will have access to reports if they wish. These can be used for appraisal, morbidity and mortality meetings or as outcome data.

From a Trust wide perspective, there will be a cumulative report produced to identify issues with quality of care, and themes of modifiable factors which will be presented quarterly to the Clinical Quality Group and the Quality and Outcomes Sub-Committee of the Trust Board.