Specialty Mortality and Morbidity Review Guidelines

University Hospitals of Leicester NHS
NHS Trust
Trust ref:B6/2023

1. Introduction and Who Guideline applies to

1.1 This document provides details of the processes involved in undertaking the different types of mortality reviews, morbidity reviews and death classification and supports the UHL Learning from Deaths of Patients in Our Care Policy B4/2023).

1.2 This guideline applies to:

a) All deaths and morbidity relating to UHL patients
b) All adult, paediatric and neonatal/obstetric patients
c) All staff involved in the M&M Process

2. Guideline Standards and Procedures

2.1 Multi-disciplinary M&M Meetings must be carried out in all Emergency Departments and In-patient Specialties with formal Terms of Reference which should reflect any national or locally agreed requirements (see appendix 1)

2.2 An M&M Lead must be identified and the role agreed as part of the annual job planning process. The M&M Lead is responsible for ensuring effective chairing of the M&M Meetings.

2.3 Clinical Staff are expected to attend M&M meetings and participate in the M&M process as set out in Appendix 2

2.4 Clear reporting mechanisms must be identified by each Speciality M&M for escalating areas of serious concern identified by reviews so appropriate action can be taken

2.5 Specialty M&M meetings should include review of the following:

- Mortality cases, as set out in the UHL M&M Reviews & Death Classification Policy
- Morbidity cases, as defined by the Specialty's Terms of Reference
- Clinical Outcomes as reported to national registers, clinical audits
- Risk Adjusted Mortality (HSMR and SHMI) for relevant Diagnostic and Procedural Groups
- Internally monitored clinical outcomes eg Hospital Acquired Thrombosis, Hospital Acquired Infections

2.6 All Child and Neonatal/Obstetric Deaths will be subject to a Mortality Review in line with National Requirements

Structured Judgment Reviews, or Clinical Reviews of Adult deaths will be undertaken in line with the UHL Learning from Deaths Policy and where potential learning or problems in care is identified through Medical Examiner scrutiny relating to

- *Assessment, Diagnosis & Management Plan*
- *Communication – with Patients & Relatives*
- *Dignity & Compassion*
- *Discharge Process*
- *Documentation: Paper/Electronic*
- *Investigations and Acting on Results*
- *Multi-Disciplinary Team Working*
- *Medications*
- Monitoring , Recognition & Escalations/Ceiling of Treatment

- *Transfer & Handover*

2.7 Morbidity reviews should be undertaken where patients have a complication of treatment, as defined by the Specialty M&M's Terms of Reference (Appendix 1).

2.8 All Mortality and Morbidity review findings must be sent to the M&M Lead for 'sign off' and where learning identified the review should be presented at the Specialty M&M meeting within 4 months of the death/morbidity.

2.9 Where either a mortality or morbidity SJR identifies a problem in care that meets the definition of a patient safety incident this must be reported on Datix as per the UHL Incident and Accident Reporting Policy.

2.10 Details of learning and actions must be documented either in the Structured Judgment Review template or Specialty M&M Minutes and actions should have lead and timescales agreed and be recorded on the Specialty M&M Action Tracker

2.11 Copies of completed SJR/Reviews and Minutes must be saved on the Shared M&M Drive and/or sent to the Corporate Learning from Deaths team

2.12 An Assurance Report should be submitted from each Speciality M&M Lead to the relevant CMG Q&S Board on an annual basis, copied to the MRC

This should include details of actions taken where M&M reviews have identified problems in health care requiring actions to be taken to prevent reoccurrence.

2.13 Exception reports for individual M&M reviews, where serious concerns raised (death considered to be more likely than not due to problems in care), must be submitted in real time to the Corporate Learning from Deaths team for escalation to the UHL Mortality Review Committee

2.14 Where joint Specialty reviews are required, support will be provided by the Corporate LfD team and the outcome of such reviews should be discussed at a Joint Specialty M&M wherever possible

3. Education and Training

3.1 The Royal College of Physicians have published the "Using the structured judgement review method - A guide for reviewers" which provides guidance on how to undertake a Structured Judgement Review

https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf

3.2 Support and advice is also available from the Corporate LfD team and advice on completion of the Learning Disability and Serious Mental Illness sections of the SJR template is available from the Lead LD Nurse and UHL Mental Health Lead respectively

3.3 Training and advice will also be provided at the BiAnnual M&M Leads Forum

4. Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
SJRs completion timescales (Mortality)	M&M Leads / HoLfD	LFD Database	Quarterly	CMG Q&S / Mortality Review Committee
% Actions Implemented/ on Track	M&M Leads / HoLfD	LFD Database	Quarterly	CMG Q&S / Mortality Review Committee
Frequency of Meetings	M&M Leads / HoLfD	Meeting Minutes against Terms of Reference	Annually	CMG Q&S / Mortality Review Committee
Attendance at M&M Meetings	M&M Leads / HoLfD	Meeting Minutes against Terms of Reference	Annually	CMG Q&S / Mortality Review Committee
Minutes of Meetings are available	M&M Leads / HoLfD	Audit of Minutes against Meetings	Annually	CMG Q&S / Mortality Review Committee

5. Supporting References

6. Key Words

M&M, Mortality Review, Morbidity Review

CONTACT AND REVIEW DETAILS	
Guideline Lead Rebecca Broughton, Head of Learning from Deaths	**Executive Lead** Andrew Furlong, Medical Director
Details of Changes made during review: New Guideline amalgamating aspects of the previous M&M Policy and the Guidelines for Specialty M&M Review Processes	

xxxxxxxx SPECIALITY MORBIDITY & MORTALITY REVIEW MEETINGS

APPENDIX 1

TERMS OF REFERENCE

Speciality / CMG	xxxxxxxx / xxxxxx CMG
Author / Originator(s):	xxxxxxxxxx
Date of Latest Review:	xxxxxx
Review Date:	xxxxxxxxxx
Approved by:	Xxxxxxxxxx Q&S Board
Date Approved:	Xx/xx/xxxx

1. Membership

Chair	Name/Job Title: xxxxxxxx
Deputy Chair (where applicable)	Name/Job Title: xxxxxxxxxxxx
Core Members	***Indicate as applicable eg:*** • *All Consultants* • *Matrons*
Associated Members / Standing Invitees	***Indicate as applicable eg:*** • *Registrars and other junior medical staff members from the specialty,* • *Ward Sisters, Clinical Nurse Specialists/Advanced Nurse Practitioners* • *Other relevant clinical staff (eg perfusionists, surgical care practitioners, etc.) and other relevant medical/pharmaceutical staff.*
Invitees when appropriate	***Indicate as applicable eg:*** • *Radiologists,* • *AHPs i.e. Physiotherapists, Dieticians* • *Affiliated Speciality Clinicians as applicable*

2. Meetings

Frequency	*Should be monthly – if less frequently, need to describe process for ensuring mortality reviews are in line with UHL policy*
Expected attendance rate of Core Members	***NOTE:*** *Consultant medical staff are required to attend the M&M Meetings as per the Terms of Reference for their speciality, with a recommended attendance as per the following standards:* *Monthly– 50% Attendance Rate (6 Meetings a yr)* *Bi-Monthly– 60% Attendance Rate (4 Meetings a Year)* *Quarterly– 75% Attendance Rate (3 Meetings a Year)*

3. Meeting Format

- **Approval of minutes** of previous meeting and update on discussions/queries, where applicable
- **Review of progress with actions** identified at previous meetings and confirmation of remedial actions being taken and revised timescales where behind schedule
- Quarterly to review outstanding actions
- **Review of Mortality Rates** for the Specialty and Diagnostic / Other relevant patient groups and discussion where applicable
- **Review of numbers of deaths** during reporting period and progress with screening, review and Death Classification of cases as per national requirements and UHL policy standards
- **Review individual Mortality cases** – where full Structured Judgement Review indicated – and to :
    - Consider learning and agree actions (to include leads and timescales as applicable)
    - Confirm whether there were problems in care and if these caused harm.
    - Agree Death Classification
- **Individual Morbidity Case reviews** and discussion
- **Any learning from Coroners cases or Patient Safety Incidents**
- **Final summing up by M&M Chairman** to include confirmation of actions

4. Selection and Timescales for Mortality Structured Judgement Review (SJR)

4.1 Selection

- Cases referred by the Medical Examiner for potential learning or confirmation of problems in care
- Deaths following an elective procedure
- Deaths where the patient had either a Learning Disability or Serious Mental Illness
- All deaths where an 'alarm' has been raised with the Trust through whatever means for either a Speciality, particular diagnosis or treatment group (eg HSMR CUSUM alert)

4.2 Timescales

Completed SJRs should be presented to the Speciality M&M and Death Classification agreed (or case referred to the Mortality Review Committee) within 4 months of death and all must be completed and presented within 6 months.

5. Selection and Timescales for Morbidity Reviews

5.1 Selection

- Morbidity reported as an Serious Incidents via Datix
- Serious or unexpected morbidity
- Cases of interest where learning can be made

5.2 Timescales

Morbidity Reviews should be presented and learning/actions agreed within 3 months of being the case being identified

6. Meeting Minutes

A summary will be offered at the end of each case discussed to include:

- Death classification, for each SJR completed/presented
- Whether there were any problems in care identified
- Learning and actions to be taken, where applicable

Minutes will be recorded and uploaded onto the UHL shared drive.

7. **Mortality Rates Reporting**

Annual Risk Adjusted Mortality, as reported by relevant national bodies, will be considered by the Specialty M&M and a summary report submitted to the CMG Q&S Board and Mortality Review Committee (MRC)

Quarterly HSMR and SHMI at a Procedure/Diagnosis Group level, as provided by the Corporate M&M Team, will be considered by the Speciality M&M and further sub analysis, case note review or other actions agreed, as applicable.
Mortality rates 'greater than expected' will require exception reporting to the CMG Q&S Board and MRC

8. Reporting Process

Minutes will be cascaded to Core Members via email or made accessible on the Speciality Shared Drive

Heads of Departments/Teams and Services will be sent copies of minutes for onward cascade accordingly

Where M&M findings identify learning for other Specialities, this will be reported to the relevant Head of Service or M&M Lead

Annual Assurance Report to the CMG Quality & Safety Board, copied to the Mortality Review Committee

9. Escalation Process

Where the Speciality M&M confirms Death Classification as 1-3 (and the case has not already been reported and actioned via the Trust's Incident and Accident Policy process, these will be reported to the CMG Clinical Director and the next Mortality Review Committee (MRC).

The MRC will advise on action to be taken, to include consideration of new referral to the Coroner and Duty of Candour requirements.

Where there is evidence of professional misconduct, or concerns regarding trainees, these will be escalated, in line with trust policies, via the Head of Service.

APPENDIX 2

M&M MEETING ATTENDANCE REQUIREMENTS:

1.1 **Medical staff:**

a. *consultant medical staff* are required to attend the M&M Meetings as per the Terms of Reference for their Specialty, with a recommended attendance as per the following standards (pro rata for staff working less than full time):

Frequency of M&M Meetings in specialty	Recommended attendance required
Monthly (recommended frequency)	50% (6 per year)
Bi-Monthly (expected frequency)	60% (4 per year)
Quarterly (minimum frequency – where less than 5 deaths per year)	75% (3 per year)

b. *all other medical staff* are also expected to participate fully in all M&M Reviews relevant to their practice and should attend M&M Meetings where clinical duties allow

c. all medical staff are expected to familiarise themselves with the outcomes of M&M discussions, (insofar as they affect their area of practice), and contribute to any resultant quality improvement initiatives, even if clinical duties do not permit attendance

d. It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time.

e. medical students should be encouraged to attend M&M Meetings.

1.2 **Matrons, Ward Sisters and Specialist Nurses**

Matrons, Ward Sisters and Specialist Nurses should attend their specialty/CMG M&M Meetings (at the frequency outlined above).

1.3 **Nurses, Allied Health Professionals and other clinical staff:**

a. All Registered Nurses (RNs) and Allied Healthcare Professionals (AHPs) are expected to participate in the M&M process as part of their clinical practice and, where clinical duties allow, to attend M&M Meetings

b. Where clinical duties do not permit attendance, RNs and AHPs are expected to familiarise themselves with the outcomes of such reviews, (insofar as they affect their area of practice), and contribute to any resultant actions and quality improvements

c. Nursing and AHP students should be encouraged to attend M&M Meetings

1.4 **All Clinicians** should consider every occurrence of patient morbidity or mortality to have the potential to be part of the review and learning process