**Mortality Review – Key work streams and progress**

1. Establish a **new trust wide mortality review group** which will (see ToR);
   * 1. Oversee all work streams as listed below
     2. Review all deaths for mental health services and all unexpected deaths for physical healthcare services, with a particular focus on those which are not reviewed as part of the SI process/ child death overview process
     3. Group will link with; physical health group, end of life and palliative care steering group and safeguarding boards around CDOP review
     4. Identify measures to show impact of work eg process changes, reduction in avoidable deaths

Progress: Terms of reference developed. Frist meeting of new group on 21st June 2016.

1. Agree and communicate standard **definitions**, responsibilities and scope of reporting a death, and level of investigation:
   * 1. Clear definition of expected and unexpected deaths
     2. Screening tool/ flow chart to be developed to support process of identifying category of death and how/ where to report on Ulysses and Carenotes and what type of investigation is required
     3. Agree scope for reporting/ investigation; currently all deaths are reported by mental health services and only unexpected deaths reported by physical healthcare services
     4. Agree process for investigation of deaths of detained patients
     5. Review method of reporting; currently the incident reporting system is used (longer term piece of work)
     6. Level of investigation ie IIRs, concise and full RCA; currently an IIR is asked for the majority of deaths. A specific report template to be developed for an initial review into any possible contributory factors prior to death.
     7. Clarity of responsibilities for reporting and level of investigation for deaths when only being seen by third sector partners in Oxfordshire Mental Health Partnership
     8. Policy to be developed on reporting and investigating deaths
     9. Agree and introduce transparency and openness charter (longer term piece of work)

Progress: Initial reporting template reviewed. Currently all deaths reported on Ulysses are discussed at the weekly clinical review meeting.

Proposed definitions, flow chart, revised initial reporting template and draft policy to be taken to first mortality review group on 21st June 2016. Lead: Paul Butler and Helen Hunt.

1. Agree **system wide approach** for review of deaths in more primary care services (ie GP OOHs, IAPT, Luther Street GP Practice) and learning from (unexpected) deaths with relevant external partner’s ie acute trusts, GPs, commissioners, third sector and drug and alcohol services. Initially map existing groups/ systems to identify gaps.

Progress: Mapping has not started yet. The review of all child deaths is led by the child safeguarding boards.

1. Improve **accuracy of data** on deaths held on incident reporting system:
   * 1. Setting up a regular check and audit trail of information held on the incident reporting system, STEIS, NRLS and local SI database
     2. Introducing a system to better record when a death is changed from being or becoming a patient safety incident (as reported on NRLS)
     3. Carry out a regular check of all current patients and those seen by services (excluding GP OOH and IAPT) in the last 6 months to pick up any deaths not reported or known. This can be done by running a list of current/ recently seen patients from the five electronic health record systems and then carrying out a trace for these patients against the national deceased database.
     4. Review how information held on death certificates can be used more effectively (certificates for all unexpected deaths are issued by the coroner)

Progress: Some work has been completed reviewing deaths by service and setting for 2014/15 and currently for 2015/16. Further work required.

1. Improve **use of data** on deaths held on incident reporting system/ electronic health record systems;
   * 1. Identify support and resources to provide data and analysis (proposal to recruit 1 WTE fixed term initially)
     2. Identify training required to analyse/ review data on deaths
     3. Carry out a regular analysis of deaths by service and team looking at a range of factors i.e. age, condition/ diagnosis, when and where death occurred, care received, medication, any co-morbidities etc..
     4. Review how data on deaths is presented by service line to focus further work and investigation.
     5. Report analysis of data and findings from thematic reviews on at least a 6 monthly basis to Trust Board
     6. Look at whether a standardised measure of mortality can be developed to assess whether the number of deaths is higher or lower than expected and compare with other organisations (see Dr Foster standardised ratio for acute trusts)

Progress: Limited progress so far.

1. **Thematic reviews**;
   * 1. Map thematic reviews of deaths completed in last 2 years eg child death overview process
     2. Develop a trust wide standard template for reviews
     3. Agree frequency and approach of reviews in each service
     4. Identify any gaps in thematic reviews for more immediate attention
     5. Review how themes and learning are disseminated (agree mechanism to feedback to frontline staff)
     6. Findings from reviews to be reported to Trust Board

Progress: Reviews of deaths across some services continue but these are ad hoc.

1. Review timeliness and approach to **involving families/ carers** (duty of candour requirements), particularly when a death is not investigated as a serious incident, and identify approach to regular monitoring. How do we know and demonstrate families/ carers are satisfied with level of involvement.

Progress: Involvement is monitored and questioned as part of SI process; however the majority of deaths are not investigated through the SI process. The Ulysses system has been adapted to include questions around duty of candour requirements when an incident is reported, however this is poorly completed. The suicide prevention lead and patient safety lead are carrying out work including running the making families count workshop.

1. **Support of staff**; review support available and offered to staff both initially and ongoing following an death (unexpected) or serious incident.

Progress: Review has not started to look at current support offered and any gaps.