Chelsea and Westminster Hospital
NHS Foundation Trust

Learning from Deaths: Mortality Review

Policy and Procedure

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APPROVAL:	**NAME:** Mortality Surveillance Group **DATE**: 6th August 2021	**CHAIR**: Dr Iain Beveridge, Hospital Medical Director (WM site)	
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LOCATION:	Policy library on Trust intranet		
RELATED DOCUMENTS:	Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths Incident Reporting, Investigation and Management Policy Duty of candour policy		
AUTHOR / FURTHER INFORMATION:	Charlotte Bartlett, Head of Clinical Governance		
STAKEHOLDERS CONSULTED:	Mortality Surveillance Group Divisional Mortality Review Groups End of Life Care Leads Patient Safety Group		

DOCUMENT REVIEW HISTORY:

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August 2017	1	Mortality Surveillance Group	Ratified August 2016
Feb 2018	2	Mortality Surveillance Group	Process flow charted updated for WCHGD
March 2021	3	Mortality Surveillance Group	Scheduled review to include refreshed process and addition of autism
August 2021	4	Mortality Surveillance Group	Re-wording of CESDI grade definitions for clarity; Updated LeDeR flowchart; Reference to 'Serious Incidents' amended to 'patient safety incidents'
NEXT REVIEW	2024		

Contents

1.	Summary	3
2.	Introduction	3
3.	Scope	3
4.	Aims and Objectives	3
5.	Definitions	3
6.	Stakeholders	4
7.	Roles and Responsibilities	4
8.	Mortality Case Review Process	
8.1	Mortality review process flow (PCD/CSD/WCHGDPP)	9
8.2	Mortality review process flow (EIC)	10
8.3	Identifying cases	11
8.4	Consultant case screening	11
8.5	Medical Examiner Scrutiny	11
8.6	Consultant-led Mortality Review	11
8.7	Divisional Mortality Review Groups	12
8.8	Mortality Surveillance Group	13
9.	Launching patient safety incident investigations from mortality reviews	13
10.	Trust response to particular categories of patient death	13
10.1	Deaths of patients with learning disabilities / autism	13
10.2	Deaths of patients with significant mental health disorders	14
10.3	Stillbirths and late fetal losses	14
11.	Publication of mortality metrics	14
12.	Distribution / dissemination	14
13.	Monitoring and Audit	15
14.	References	16
	Appendix 1 – Divisional Mortality Review Group terms of reference (example)	17
	Appendix 2 – Outline of the national learning disabilities mortality review process	19

1. SUMMARY

This procedure describes the Trust wide process of retrospective case review that is to be implemented following an in-hospital death. The document outlines roles and responsibilities and provides guidance on the process of identifying, reviewing, sharing and escalating mortality case reviews.

2. INTRODUCTION

The NHS Quality Board published a Framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care in April 2017. One of the regulations set out within the framework (Chapter 1 sections 6, 12 and Annex C – Responding to Deaths) states that "Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under their management and care."

Learning from mortality will be used to drive service improvement and offer assurance to our patients, stakeholders and the Board that the causes and contributory factors of patient deaths have been considered and appropriately responded to in an open and transparent manner.

This Trust-wide approach to learning from death has been developmed with the aim of ensuring a standardised format and process. This will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning.

3. SCOPE

This policy and procedure applies to all staff who may be involved in the provision of care or service to patients; this includes medical staff, nurses, and allied healthcare professionals. Every member of staff must be empowered and supported to engage with the mortality review / learning from deaths process.

Where staff are uncertain of their requirements within this document or how to support the process of learning from deaths, advice should be sought from their Service Director, Clinical Director or Divisional Medical Director. Further guidance is available from the Quality and Clinical Governance Department.

This policy applies to all in-hospital deaths within Emergency & Integrated Care, Planned Care, Clinical Support. Within WCHGDPP Division, the policy applies to cases within Paediatrics, HIV, Gynaecology, Dermatology. Maternity cases outside the scope of the PMRT are also included.

3.1. Exclusions

Cases referred as part of the Perinatal Mortality Review Tool (PMRT) are excluded from the mortality review process hosted within Datix. Performance reports arising from case reviews within the PMRT will receive trust scrutiny in the same way as for all other in-hospital deaths.

Deaths occurring outside the organisation are excluded

4. AIMS AND OBJECTIVES

- To improve patient safety and the quality of care provided by the Trust through the engagement of staff in a consistent and robust process of retrospective case record review following in-hospital deaths.
- To establish multi-disciplinary and multi-professional forums within which potential areas of improvement in both individual cases and the way the Trust delivers services as a whole are considered.
- To ensure there are clear reporting mechanisms in place to escalate any area of potential suboptimal care so the Trust Board is aware and can support corrective action.
- To ensure mortality reviews are undertaken and the outcomes from review are securely recorded and accessible for audit, analysis and trend recognition via the Datix Mortality module.

5. DEFINITIONS

- **Case review**: A structured desktop review of a case record carried out by clinicians to determine whether there were any problems in the care provided to a patient, or notable learning suitable for sharing with clinical colleagues.

- **CESDI**: Confidential Enquiry into Stillbirths and Deaths in Infancy categorisation adopted by the Trust to identify whether deaths were avoidable and/or if there was suboptimal care.
- **Learning Disabilities**: A person with learning disabilities has a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) and a reduced ability to cope independently (impaired social functioning) which started before adulthood and had a lasting effect on their development.
- **Screening**: Contains a series of statements, which the consultant responsible for the patient's care signs as either 'agree' or 'disagree'. Agreement with all statements may allow a case to be diverted away from full mortality reviews.
- **Full mortality review**: Full mortality review using a generic template. Variations between services may occur but each version contains a core data set.
- **M&M**: Mortality and Morbidity meeting held by clinical teams to discuss potential problems in care provision and learning following deaths, complication or unexpected clinical events.
- **PMRT:** the Perinatal Mortality Review Tool is a national programme to support standardised perinatal mortality reviews across NHS maternity and neonatal units.

6. STAKEHOLDERS:

The Divisional Mortality Review Groups, Mortality Surveillance Group, Patient Safety Group and the Quality Committee will support development and dissemination.

7. ROLES AND RESPONSIBILITIES

7.1 Board of Directors

The Board of Directors are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust. The Board must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths. The Board will nominate a lead Non-Executive Director to consider assurance evidence from the Trust's learning from death process.

7.2 Chief Executive

Has overall responsibility and accountability for ensuring the Trust has appropriate learning from death procedures in place.

7.3 Medical Director

The Medical Director will assure the Board the learning from deaths process is functioning effectively and ensure arrangements are in place to provide collated Trust level data on mortality rates, reviews of deaths, and actions taken to address deficiencies in care and/or processes.

7.4 Hospital Medical Director (WestMid)

The Hospital Medical Director (WestMid) is the Trust lead for mortality with overarching responsibility to ensure the learning from death process is embedded across the organisation and learning is used to improve service delivery.

The Hospital Medical Director (WestMid) will:

- Chair the Mortality Surveillance Group (MSG)
- Receive assurance at MSG of Divisional engagement with the learning from deaths process and where necessary, escalate any issues to PSG and EMB.
- Feedback concerns raised at the MSG to the Quality Committee
- Escalate urgent remedial actions or concerns to the Executive Management Board

7.5 Associate Director of Quality Governance

The Associate Director of Quality Governance is responsible for ensuring key governance outcomes are supported by the learning from deaths process.

The Associate Director of Quality Governance will:

- Coordinate issues relating to identification and escalation of Patient Safety Incidents
- Coordinate issues relating to the recognition of risks for recording within Divisional risk registers
- Coordinate issues when potential learning for external agencies has been identified by the Medical Examiner
- Ensure that the system used to capture mortality case reviews and medical examiners scrutiny records is well maintained and appropriately supported.

7.6 Clinical Governance

Are responsible for reporting divisional mortality review and performance data to local governance forums and providing a liaison between the Medical Examiner's Office and the specialties they represent when potential learning has been identified via ME scrutiny.

The Clinical Governance team will:

- Supply mortality review and mortality performance data to enable mortality reporting via the monthly divisional quality reports and in accordance with this policy
- Via the monthly divisional mortality reports, monitor that cases identified for full mortality review receive that review and are closed within the required timeframe
- Alert appropriate leads when mortality screening and review are overdue and escalate where appropriate
- Provide training and support of specialty teams in respect to the mortality review process
- Support the review of cases of potential sub-optimal care at the Divisional Mortality Review Groups, with escalation through to the incident process if necessary.

7.7 Divisional Medical Directors

The Divisional Medical Directors (DMD) are responsible for ensuring the learning from death process is implemented within their Division.

The Divisional Medical Directors will:

- Ensure each Specialty operates routine mortality and morbidity (M&M) meetings
- Ensure their Division operates a monthly Mortality Review Group, led by a nominated Clinical Director
- Ensure there are suitable governance structures in place to facilitate learning from deaths in accordance with this policy and providing assurance to the Trust Mortality Surveillance Group and Board
- Support and advise colleagues involved with the mortality review process
- Retain oversight of compliance with the mortality review process
- Ensure any actions identified in relation to mortality review are recorded, progressed and monitored appropriately
- Ensure that 100% of deaths aligned to the division are subject to mortality screening
- Ensure *no less* than 30% of the total number of deaths aligned to EIC Division and 80% within Planned Care and WCHGDPP Divisions are subject to full mortality review

7.8 Nominated Clinical Director

The nominated Clinical Director is the senior clinician with management responsibility to oversee the mortality review process within their Division.

The nominated Clinical Director for the Division will:

- Coordinate and chair the Divisional Mortality Review Group, ensuring oversight and monitoring of their mortality data, with support for the processes set out in this policy and providing assurance to the Trust Mortality Surveillance Group
- Support and advise colleagues involved with the mortality review process
- Ensure any actions identified in relation to mortality review are recorded, progressed and monitored appropriately

7.9 Clinical Directors/Service Directors

Clinical and Service Directors are senior clinicians with responsibility to oversee the mortality review process within their clinical teams and Specialty M&Ms.

The clinical and service directors will:

- Co-ordinate and chair the Specialty Mortality and Morbidity Groups (M&M)
- Support their teams to conduct timely / effective case presentations
- Ensure deaths aligned to the Specialty are discussed by a multidisciplinary team
- Close any cases assigned CESDI 0 by the Specialty M&M
- Represent their Specialty at the monthly Divisional Mortality Review Group to scrutinise trends, identify themes and foster shared learning

7.10 Consultants

Consultant teams will review all adult, child and neonatal death using the mortality screening tool and will identify cases that require further review through the full mortality review form (on Datix). In addition, consultants are responsible for ensuring that any deficiencies in care, systems and/or process identified through the review process are shared and escalated through the divisional structures so as to facilitate wider organisational learning.

Consultants will:

- Undertake mortality screening
- Undertake full mortality review for identified cases
- Present mortality reviews at Local / Specialty mortality review group within 45 days of death

7.11 Learning Disabilities Mortality Lead (Lead Nurse for Learning Disabilities and Transition)

Reviews relating to patients with Learning Disabilities will be supported by / include the Lead Nurse for Learning Disabilities and Transition who will support consultants and specialty mortality leads consider learning disabilities issues when reviewing deaths.

The Learning Disabilities Mortality Lead will:

- Notify the National Learning Disabilities Mortality Review Programme of deaths of relevant deaths
- Support the initial review processes with consultant
- Attend local / specialty mortality reviews when deaths of patients with learning disabilities or autism scheduled
- Contact family members of people with learning disabilities to involve them in the review as appropriate
- Coordinate multiagency / organisation review arrangements where required
- Submit mortality reviews to the National Learning Disabilities Mortality Review Programme

7.12 PMRT Leads

Responsible for ensuring all relevant deaths are reviewed, with quarterly assurance reporting to the trust Mortality Review Group

7.13 Medical Examiner's Officers

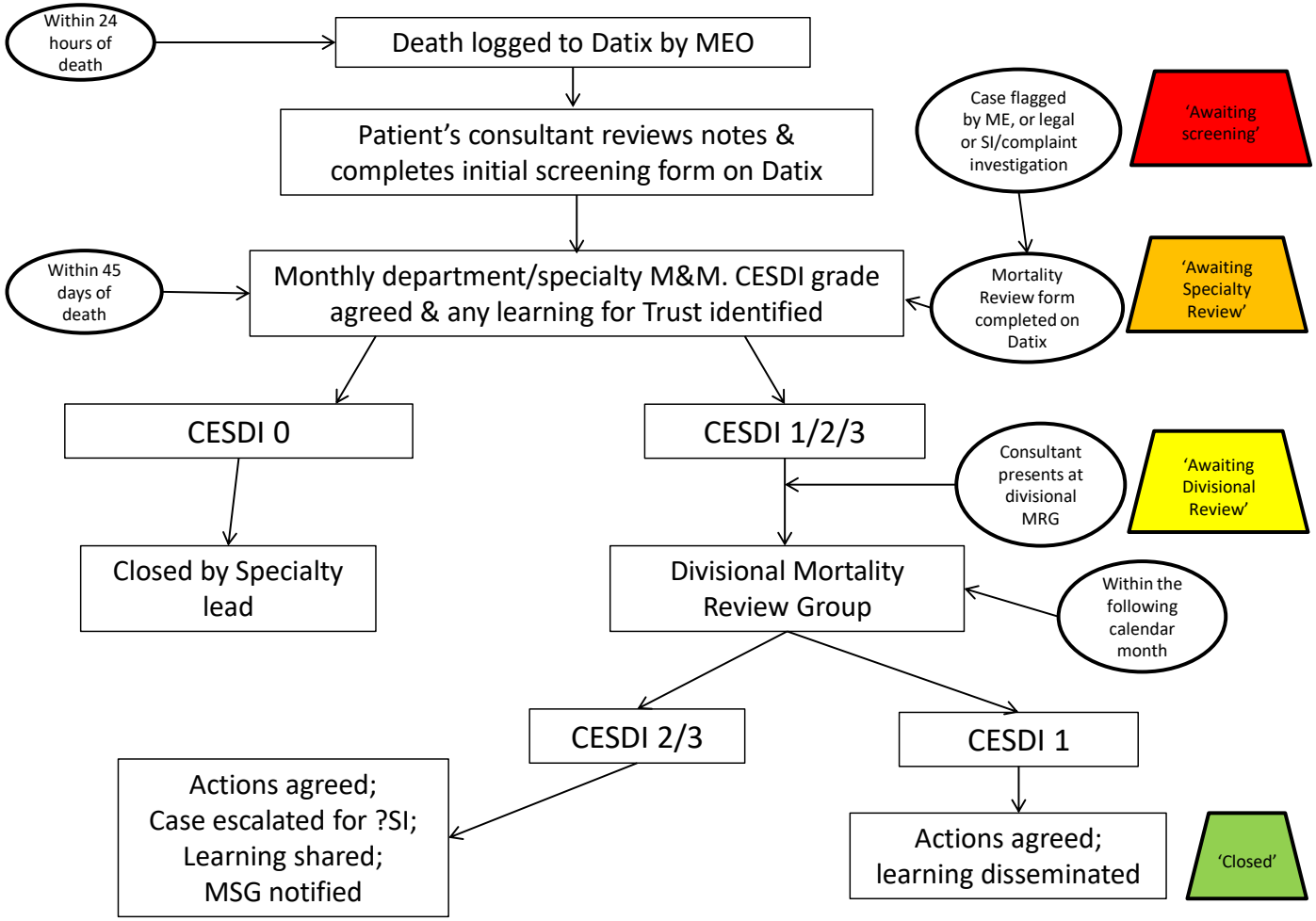
All in-hospital deaths will be recorded within the Datix Mortality module by the Medical Examiner's Officers.

Process flows for mortality review are below.

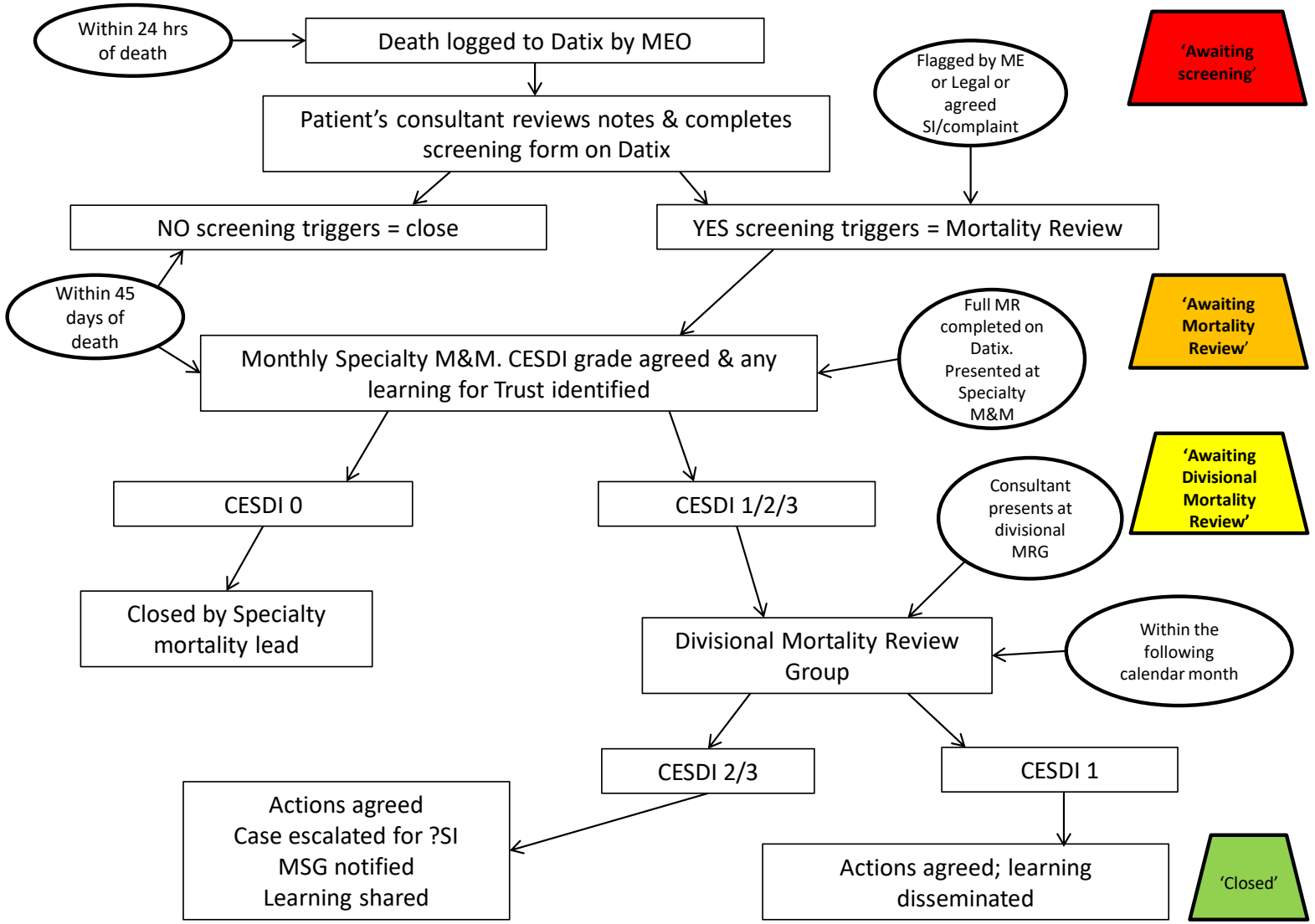
8. MORTALITY REVIEW PROCESS

8.1. Mortality review process flow for Planned Care, Clinical Support and WCHGDPP (excluding PMRT cases) Divisions

Mortality review process flow:



8.2. Mortality review process flow for Emergency & Integrated Care Division



8.3. IDENTIFYING CASES

The Datix Mortality module provides a standardised platform for the recording and management of Consultant led mortality case reviews. The use of Datix promotes visibility, supports escalation and provides assurance that learning opportunities are being sought following in-hospital death.

All in-hospital adult, child deaths are recorded within the mortality module by the Medical Examiner's Office within 1 working day of death. For the purposes of this procedure these categories of in-hospital mortality are defined as:

- Adult death: Death of patient who is 18 or more years old
- Child death: Death of patient who is older than 28 days and younger than 18 years

8.4. CONSULTANT CASE SCREENING

New cases logged within Datix trigger automatic email notifications to the patient's named consultant and the specialties nominated consultant team requesting completion of the mortality screening tool . Screening involves a suitable consultant providing a brief clinical review of the episode of care; this is completed on Datix using a list of 'yes/no' prompts.

If the answer to any of the screening questions is 'yes' , the case will undergo consultant led review at a local specialty Mortality and Morbidity (M&M) meeting.

8.5. MEDICAL EXAMINER SCRUTINY

The Medical Examiner's Office was established to improve the quality of death certification, to improve the experience of bereaved relatives, and to ensure appropriate referrals are made to HM Coroner. The Medical Examiner scrutiny process also gives rise to the opportunity to potential identify learning from deaths.

As part of the Medical Examiner's scrutiny the following will be identified:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- All deaths that have been referred to HM Coroner for inquest
- All deaths that were deemed to be unexpected / unanticipated
- All deaths where the Medical Examiner identifies the potential for learning

If these factors are identified the case will undergo consultant led review at a local specialty Mortality and Morbidity (M&M) meeting.

8.6. CONSULTANT LED MORTALITY REVIEW

Every case flagged for full mortality review should be discussed at a local / specialty meeting with responsibility for reviewing and sharing the outcome of mortality review e.g. mortality review groups, M&M, MDTs.

Meetings should:

- Be attended by multi-disciplinary members of the local / specialty team
- Involve at least one consultant not directly involved in the care of the patient
- Involve the Learning Disabilities Mortality Lead for patients with learning disabilities or autism
- Include input of senior clinicians from other relevant specialities when required
- Meet regularly (at least monthly)

The purpose of the local / specialty meeting is to:

- Discuss mortality reviews linked to that local team / specialty
- Ensure that reviews are of a sufficient quality to reach conclusions / identify learning
- Consider expectations and outcomes

- Agree conclusions and outcome / CESDI grading from case review
- Provide a forum to share and disseminate learning from case review

The consultant team are asked to record the outcomes from the mortality review within a standardised electronic form in the Datix Mortality module within a target of 45 days from the date of death. Each review will include the following sections:

- Situation: mode of admission, admitting diagnosis, procedures undertaken, outcome)
- Background: relevant medical history, comorbidities, lab / imaging results, interventions, observations, recognition / management of complications, escalations, end of life care, learning disabilities
- Assessment and analysis: causes of outcome, conclusions regarding any problems in care provision.

When judging if problems in care occurred reviewers are asked to consider:

- Acts: such as incorrect treatment or management
- Omissions: such as failure to monitor, diagnose, escalate, treat or deliver the expected standard of care
- Harm: resulting from unintended or unexpected complications of healthcare.

The consultant team is required to indicate outcome avoidability and / or suboptimal care provision using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the organisation:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable

In all cases where suboptimal care was judged to have occurred case reviewers are asked to consider how problems could have been prevented or better managed and to recommend improvement actions.

When assessing sub-optimal care, this refers to care within the Trust; sub-optimal care occurring outside the organisation is excluded.

8.7. DIVISIONAL MORTALITY MONITORING AND REVIEW GROUPS

The Divisional Medical Director will identify a suitable monitoring group, led by a Clinical Director, to meet at least monthly. The purpose of the group will be to:

- Monitor compliance with this policy across the Division
- Discuss trends, actions and learning from mortality screening and review
- Consider in detail all cases where suboptimal care has been identified, agreeing the CESDI grade and if necessary, escalating the case for consideration as an incident
- Support the development and delivery of improvement actions
- Coordinate / disseminate cross specialty learning from mortality review
- Escalate identified issues, themes and notable learning to the Mortality Surveillance Group

The group will ensure full mortality reviews are undertaken for all cases where consultant screening or Medical Examiner Scrutiny has identified:

- Care or service delivery concerns / potential for further learning
- Significant concerns raised by the bereaved
- HM Coroner referral
- Unexpected death
- The patient had learning disabilities or autism

- The patient had been detained under the Mental Health Act
- The death occurred in an area where people are not expected to die (e.g. during an elective procedure)
- The death occurred in ED
- The death occurred in surgery/theatres
- The death is linked to a Serious Incident investigation or a complaint investigation
- The death is linked to nosocomial COVID-19

On a monthly basis the Divisional Triumvirate will identify a sample of cases that do not fit this criterion and direct clinical teams to undertake full mortality reviews.

See Appendix 2 for example of divisional mortality monitoring group terms of reference

8.8. MORTALITY SURVEILLANCE GROUP (MSG)

The Mortality Surveillance Group provides Executive led scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review / learning from death. The Mortality Surveillance Group (MSG) will:

- Provide assurance to the Board regarding patient mortality
- Monitor and consider mortality data / analysis from internal and external sources
- Receive assurance reports from Divisional representatives
- Assign clinical leads to address key trends / issues and monitor actions
- Oversee actions arising from alerts received from the Care Quality Commission or identified by other mortality monitoring information systems (e.g. SHMI) and direct mortality reviews as required
- Support cross Divisional learning from death
- Ensure all cases graded as CESDI 2 / 3 have resulted in a Patient Safety Incident Investigation

9. LAUNCHING PATIENT SAFETY INCIDENT INVESTIGATIONS FROM MORTALITY REVIEWS

Where mortality reviews conclude that significant suboptimal care occurred (e.g. CESDI grade 2 or 3) an in-depth investigation into the care provided to that patient may be launched under the patient safety incident investigation process.

See the 'Incident Reporting, Investigation and Management Policy' for details relating to the management of patient safety incidents and the 'Duty of candour policy' for details of the Trust's commitment to include patient's families within the investigation process.

10. TRUST RESPONSE TO PARTICULAR CATEGORIES OF PATIENT DEATH

10.1. DEATHS OF PATIENTS WITH LEARNING DISABILITIES OR AUTISM

The National Learning Disabilities Mortality Review (LeDeR) Programme was established in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities; the inquiry found that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with had better quality healthcare been provided.

The LeDeR programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. To support this aim the Trust is committed to ensure deaths of patients with known / pre-diagnosed learning disabilities are reported to the LeDeR programme and reviewed in line with the programme requirements. This process will be supported by the Trust Learning Disabilities Mortality Lead.

Case reviewers are asked to identify patients with known / previously diagnosed learning disabilities within the standard mortality review form. Where patients with learning disabilities are identified the Learning Disabilities Mortality Lead will be automatically notified.

All internal review arrangements outlined in section 8 of this procedure are to be undertaken, however, following the identification of a mortality review linked to a patient with learning disabilities:

- The Learning Disabilities Mortality Lead should be included in the initial review preparation by the named consultant
- The Learning Disabilities Mortality Lead should be invited by the Specialty Mortality Lead to the specialty mortality review group / M&M when the case is scheduled for discussion

The Learning Disabilities Mortality Lead will:

- Notify the LeDeR Programme of deaths of patients with learning disabilities
- Contact family members of people with learning disabilities to involve them in the review as appropriate.
- Coordinate multiagency / organisation review arrangements where required
- Submit mortality reviews to the National Learning Disabilities Mortality Review Programme

See Appendix 3 for outline of the LeDeR process

10.2. DEATHS OF PATIENTS WITH SIGNIFICANT MENTAL HEALTH DISORDERS

Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are therefore required to ensure that there is an appropriate investigation into the death of any patient detained, or liable to be detained under the Mental Health Act who dies in their care. The trust will therefore ensure that all patients meeting these criteria are subjected to level 2 consultant led mortality review.

10.3. STILLBIRTHS AND LATE FETAL LOSSES

The Department of Health have commissioned, in collaboration with Healthcare Quality Improvement Partnership (HQIP) and MBRRACE-UK a national standardised Perinatal Mortality Review Tool (PMRT). Its aim is to standardise the reporting of perinatal deaths across all maternity and neonatal units. The Mortality Surveillance Group will receive assurance reporting from PMRT cases on a quarterly basis.

11. PUBLICATION OF MORTALITY METRICS

The following mortality metrics will be published via a quarterly return to the Public Board:

- Number of deaths within the Trust
- Number of deaths subject to mortality case screening
- Number of deaths subject to full mortality case review
- Percentage of deaths subject to mortality case review compared with total deaths (by division)
- Number of deaths investigated under the Serious Incident framework
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- Themes and issues identified from review and investigation
- Actions taken in response and actions planned

The review of mortality metrics at Board level is mandated within the national Learning from Deaths framework.

12. DISTRIBUTION/DISSEMINATION

This policy will be distributed via the Mortality Surveillance Group and Patient Safety Group. Divisional Management teams are requested to disseminate / discuss the requirements outlined in the document within their teams. The policy will be made available on the Trust intranet.

13. MONITORING AND AUDIT

Key process/part of this policy for which compliance or effectiveness is being monitored	**Monitoring method (i.e. audit, report, on-going committee review, survey etc.)**	**Job title and department of person responsible for leading the monitoring**	**Frequency of the monitoring activity**	**Monitoring Committee responsible for receiving the monitoring report/audit results etc.**	**Committee responsible for ensuring that action plans are completed**
Completion of Mortality Review within timeframe (45 days)	Report	Divisional Clinical Governance Manager	Monthly monitoring report	Divisional Mortality Review Group	Mortality Surveillance Group (MSG)
Percentage of Mortality Reviews compared with total deaths	Report	Divisional Clinical Governance Manager	Monthly monitoring report	Divisional Mortality Review Group	Mortality Surveillance Group (MSG)
Identification of sub-optimal care	Number of cases of suboptimal care identified post review compared with total number of cases	Chair of Divisional Mortality Review Group	Monthly	Divisional Mortality Review Group	Mortality Surveillance Group (MSG)
Quality of local screening and mortality review	Annual audit	Divisional Triumvirate (via identified lead auditor)	Annual	Divisional Mortality Review Group	Mortality Surveillance Group (MSG)

14. REFERENCES

CQC (2016) Learning, candour and accountability: A review of the wway NHS trusts review and investigate the deaths of patients in England

National Guidance on Learning from Deaths, April 2017
https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

NHS England National Learning Disabilities Mortality Review (LeDeR) Programme resources, http://www.bristol.ac.uk/sps/leder/resources/

Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis, Hogan et al, 30 May 2015
http://www.bmj.com/content/351/bmj.h3239

Appendix 1 – Divisional Mortality Monitoring Group Terms of Reference (example)

Divisional Mortality Monitoring Group

Terms of Reference

1. Constitution

The [**DIVISION / SITE]** is established as a sub-group of the Mortality Surveillance Group which reports to the Quality Committee.

2. Authority

The Divisional Mortality Monitoring Group is accountable to the Mortality Surveillance Group and is authorised to:

- Carry out any activity within its terms of reference;
- Request any information it requires from any employee of the Trust (and all employees are directed to comply with any request of the Group);
- Secure the attendance of outsiders with relevant experience and expertise as it considers necessary for the proper discharge of its duties.

3. Aim

The aim of the Divisional Mortality Monitoring Group is to provide senior management team scrutiny to the outcome of mortality review and to provide a forum where learning from case review can be shared and acted upon by Divisional leads.

4. Objectives

Specific duties of the Mortality Review Group include:

- To oversee the Divisional Mortality Review processes
- To ensure that all deaths within the division matching the following criteria are have undergone mortality review (level 2) and that outcomes have been recorded within the datix mortality module:
    - Care or service delivery concerns (identified at screening / level 1) /
    - Potential for further learning (identified at Medical Examiner scrutiny)
    - Significant concerns raised by the bereaved
    - HM Coroner referral
    - Unexpected death
    - Patients with learning disabilities
    - Patients that have been detained under the mental health act
    - Where deaths occurred in areas where people are not expected to die
    - Where deaths are linked to a Serious Incident Investigation
- To select a cohort of cases that do not fit the above criteria to ensure that no less than 30% of all deaths aligned to the Division have undergone level 2 mortality review
- To ensure all deaths aligned to the Division with identified sub-optimal care are discussed at the Group and that findings are presented to the Trust wide Mortality Surveillance Group.
- To act on issues escalated from Specialty Mortality Review Groups
- To scrutinise the trends, actions and learning from Mortality Reviews
- To escalate identified issues, themes or notable learning to the Mortality Surveillance Group

- To ensure risks identified through mortality review are recorded and mitigated within the risk register
- To provide assurance to the Mortality Surveillance Group on all areas of its function
- To support the delivery of the Trust mortality management plan

5. Method of working and monitoring effectiveness

The Group may request the presence of any Clinician to provide an update on individual specialty reviews.

6. Membership

The Members of the Divisional Mortality Monitoring Group shall comprise:

- Divisional Medical Director / Clinical Director (Chair)
- Clinical Directors
- Specialty Mortality Leads / Service Directors
- Quality and Clinical Governance representative

Nursing, AHP, safeguarding and learning disability representatives are invited to attend should an individual case require their input.

To foster learning and open communication, invitations are extended to all doctors aligned to the Division.

Meetings of the Divisional Mortality Monitoring Group shall not be held in public.

7. Quorum

The quorum shall be 4 members, to include the chair or a deputy, 1 Clinical Directors or deputy, 2 Specialty Mortality Leads or deputies.

8. Nominated Deputies

Members are expected to identify a deputy for occasions they are unable to attend.

9. Frequency of meetings

The Divisional Mortality Monitoring Group will meet monthly.

Attendance at meetings will be monitored and group members are expected to attend a minimum of 75% of meetings throughout the year. Attendance falling below this level will be reviewed by the chair.

10. Secretariat

Papers, minutes, action tracker and agenda are to be circulated by ***[ENTER JOB TITLE]***

11. Review process

The Mortality Surveillance Group will review these Terms of Reference on an annual basis.

Reviewed by:
Date:
Approved by:
Date:
Next review date:

Appendix 2 - Outline of the National Learning Disabilities Mortality Review (LeDeR) process