Chelsea and Westminster Hospital NHS
NHS Foundation Trust

LEARNING FROM DEATHS
MORTALITY REVIEW PROCEDURE

START DATE:	**August 2016**	**NEXT REVIEW DATE:**	**July 2018**	**EXPIRY DATE:**	**October 2018**
COMMITTEE APPROVAL:		**NAME OF COMMITTEE** **Patient Safety Committee**		**NAME OF CHAIR OF APPROVING COMMITTEE** **Zoe Penn, Medical Director**	
		DATE APPROVED: 02/08/2017			
		ENDORSED BY: **Mortality Surveillance Group**		**DATE:** **June/July 2017**	
DISTRIBUTION:		Trust-wide			
LOCATION:		Intranet – Trust Policies			
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:		Alex Bolton, Safety Learning Programme Manager			
STAKEHOLDERS INVOLVED:		This policy will be promoted through the Patient Safety Group and Mortality Surveillance Group.			
FRONT LINE STAFF APPROVAL (NAME AND DESIGNATION)					
DOCUMENT REVIEW HISTORY:					

Date	**Version**	**Responsibility**	**Comments**
August 2017	V1	Safety Learning Programme Manager	Flowchart and links to Datix mortality module considered at Patient Safety Group in August 2016. Added sections relating to stakeholders, Datix mortality module, Deaths requiring mortality review, Identifying in-hospital mortality, Initial case review, Local / specialty mortality review group, Divisional mortality review group, Mortality surveillance group, Launching serious incident investigations from mortality reviews, Trust response to particular categories of patient death, Publication of mortality metrics, distribution and dissemination.

Contents

1. SUMMARY

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

2. INTRODUCTION

The Care Quality Commission published 'Learning, candour and accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England' in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted the reports recommendation and announced new measures designed to improve learning following patient deaths.

The NHS Quality Board published a Framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care in April 2017. To support this agenda the Trust has committed to review all in-hospital death at local / specialty level mortality group where teams will have the opportunity to review expectations, outcomes and learning in open discussion within a multi-disciplinary / multi-professional group. Where issues in care, trends or notable learning are identified action is to be steered through Divisional Mortality Review Groups and the trust wide Mortality Surveillance Group.

The learning from mortality case review will be used to drive service improvement and offer assurance to our patients, stakeholders and the Board that the causes and contributory factors of all deaths have been considered and appropriately responded to.

This Trust-wide approach to case review has been development 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 procedure applies to all staff that may be involved in the provision of care or service to dying patients; this includes medical staff, nurses, allied healthcare professionals and support services such as Bereavement / Patient Affairs. Every member of must be empowered 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.

4. AIMS AND OBJECTIVES

- To improve patient safety and the quality of care provided by the Trust through the engagement of staff in a single, consistent and robust process of retrospective case record review following all 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 that there are clear reporting mechanisms in place to escalate any area of potential suboptimal care so that 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 used to identify whether deaths were avoidable or if there was suboptimal care.
- **DMRG**: Divisional Mortality Review Group
- **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.

- **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.
- **MDT**: Multi-disciplinary team.

6. STAKEHOLDERS:

The Mortality Surveillance Group and Patient Safety Group will support development and distribution.

7. ROLES AND RESPONSIBILITIES

Medical Director
The Medical Director will assure the Board that the mortality review process is functioning correctly and ensure that arrangements are in place so that staff are aware of their responsibilities.

Associate Medical Director (WestMid)
The Associate Medical Director (WestMid) is the Trust lead for mortality; they have overarching responsibility to ensure the mortality review process is embedded across the organisation and learning is used to improve service delivery.

The Associate Medical Director (WestMid) will:
- Chair the Mortality Surveillance Group (MSG)
- Feedback concerns raised at the MSG to relevant Divisional management teams and the Patient Safety Committee
- Escalate urgent remedial actions or concerns to Executive team

Director of Quality Improvement
The Director of Quality Improvement is responsible for ensuring key governance outcomes are supported by the mortality review process.

The Director for Quality Improvement will deputise for the Trust Mortality Lead and will support the Mortality Surveillance Group in relation to:
- Issues relating to identification and escalation of Serious Incidents
- Issues relating to Being Open and Duty of Candour requirements
- Issues relating to the recognition of risks for recording within Divisional risk registers

Divisional Medical Director
The Divisional Medical Director (DMD) is responsible for ensuring the mortality review process is embedded within their Division.

The Divisional Medical Director will:
- Chair the Divisional Mortality Review Group (DMRG)
- Ensure all cases of identified suboptimal care (CESDI grade >0) are considered by the DMRG
- Support and advise colleagues involved with the mortality review process
- Monitor compliance with the mortality review process
- Establish systems of Division wide learning from mortality review
- Ensure that any actions identified in relation to mortality review are recorded, progressed and monitored appropriately

Specialty Mortality Leads (Service Directors / Leads)
Specialty Mortality Leads are appointed by the Divisional Medical Director as individuals with management responsibility or specialist knowledge appropriate to oversee the mortality review process within their clinical team(s).

Specialty Mortality Leads will:
- Chair the Specialty Mortality Review Group (SMRG)
- Support their teams to conduct timely / effective case presentations
- Ensure all in-hospital deaths aligned to the specialty are discussed by a multidisciplinary team
- Close / accept completed mortality reviews on the Datix mortality module

Case Reviewers - Named Consultants / Stillbirth & late fetal loss leads

Adult, child and neonatal death will be reviewed by the Consultant responsible for the patients care (last episode of care). Stillbirths & late fetal losses will be reviewed by the sites Stillbirths & late fetal loss leads.

Case reviewers will:

- Review cases within 4 weeks of assignment
- Record the situation, background, assessment, CESDI grade within the Datix mortality module
- Present the case to the Specialty mortality review group
- Report suboptimal care or unavoidable death on the Datix incident module.

Learning Disabilities Mortality Lead (Lead Nurse for Learning Disabilities and Transition)
Reviews relating to patients with Learning Disabilities will be supported by / include the Learning Disabilities Mortality Lead. They 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 named consultant
- Attend local / specialty mortality reviews when deaths of patients with learning disabilities 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

Patient Affairs / Bereavement
All in-hospital deaths will be recorded within the Datix Mortality module by the Patient Affairs / Bereavement teams.

8. MORTALITY REVIEW PROCESS

8.1. MORTALITY REVIEW PROCESS FLOWCHART

The flowchart below outlines the process of undertaking a mortality review

Case creation – completed within 1 working day
Following receipt of notification of death / pregnancy loss the Bereavement / patient affairs team will:

- Creates a new case on the Datix mortality module
- Records key patient details
- Confirms Specialty and ward / location associated with patient (last episode of care)
- Links named consultant / person responsible for initial review

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Initial case review – completed within 4 weeks
The case reviewer (named consultant or lead for stillbirth / late fetal loss) will:

- Record the situation (Admitting diagnosis, procedures, outcome)
- Record the relevant background (Relevant medical history, comorbidities, lab / imaging results, interventions, observations, recognition / management of complications, escalations)
- Record the case assessment and analysis (CESDI grade, conclusion, causes of the outcome)

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Local / Specialty Mortality Review Group – at least monthly
All cases are review by Specialty Mortality Review group chaired by Specialty Mortality Lead (Service Director / Lead). Group considers and agrees conclusions, learning, actions and CESDI grade

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Divisional Mortality Review Group – monthly
All cases with suboptimal care (CESDI grade>0) reviewed by Divisional Mortality Review Group (or other group with appropriate remit) chaired by Medical Director / Clinical Director. Group monitors and supports process, learning, actions and recommendations

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Trust wide Mortality Surveillance Group – monthly
Trends, actions and learning monitored by the Mortality Surveillance Group chaired by the Trust Mortality Lead.

8.2. DATIX MORTALITY MODULE

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 every in-hospital death.

All staff registered with the General Medical Council have access to the Mortality Module and can review cases to which they have been logged as the patient's named Consultant (last episode of care) or where a colleague has specifically shared the case with them.

8.3. DEATHS REQUIRING MORTALITY REVIEW

All in-hospital adult / child / neonatal deaths, stillbirths and late fetal losses require mortality case review. 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
- Neonatal death: Live baby delivered at 20+0 weeks gestation or later and dies within 28 days of birth
- Stillbirth: Baby delivered at/after 24+0 weeks gestation with no signs of life
- Late fetal loss: Baby delivered between 22+0 and 23+6 weeks gestation with no signs of life

Out of hospital deaths will be reviewed as per this procedure where an external organisation suggests that review of care previously provided by the Trust would support learning / process of coordinated multi-organisational mortality review. Where an external organisation identify issues / problems in care previously provided by the Trust the Incident Reporting and Investigation

8.4. IDENTIFYING IN-HOSPITAL MORTALITY

Notification of death / notification of pregnancy loss forms are completed by the patient's clinical team following in-hospital death; notification forms are processed by the Bereavement / Patient Affairs department. See linked 'Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths' for details of the notification process and supporting documentation.

Following receipt of a notification form the Bereavement / Patient Affairs team will generate a new case in the mortality module within one working day, when logged each case will include as a minimum:

- Enters key patient details (e.g. name, date of birth, date of admission, date of death, hospital number)
- Management team overseeing review (e.g. Specialty associated with last episode of care)
- Individual responsible for leading initial review (e.g. named consultant or lead for stillbirths / late fetal losses)

Causes of death and coroner referral outcomes will be logged to the case as this information becomes available to the Patient Affairs / Bereavement team.

Where external organisations request review of out of hospital deaths the Associate Medical Director (WestMid) will consider mortality learning from the external organisation and confirm applicability for further review / logging within Trust mortality module with the Bereavement / Patient Affairs department.

8.5. INITIAL CASE REVIEW

New cases trigger automatic email notifications to the person responsible for undertaking the initial review (e.g. the named consultant or stillbirth / late fetal losses lead) and the mortality lead for the associated specialty (e.g. person responsible for ensuring case is discussed at local / specialty mortality review group).

Case reviewers are asked to consider all aspects of patient care; including medical, nursing and allied health professional involvement; to determine whether there were any problems in the care provided or notable learning from the case.

Case reviewers are asked to record the outcomes from their review within a standardised electronic form in the Datix Mortality module within a target of 4 weeks 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.

Reviewers are asked to assess outcome avoidability and / or suboptimal care provision using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories. The CESDI grades are:
- Grade 0: Unavoidable death, no suboptimal care
- Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

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.

8.6. LOCAL / SPECIALTY MORTALITY REVIEW GROUP

Every in-hospital death 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 chaired by the identified Mortality Lead
- Attended by multi-disciplinary members of the local / specialty team
- Be promoted to Junior Doctors aligned to the specialty
- Meet regularly (at least monthly)

The purpose of the local / specialty meeting is to:
- Discuss every mortality review linked to that local team / specialty
- Ensure that reviews are of a sufficient quality to reach conclusions / identify learning
- Consider expectations and outcomes from each in-hospital death
- Raise any relevant information relating to the patient not included in the case review
- Agree conclusions and outcome / CESDI grading from case review
- Provide a forum to share and disseminate learning from case review

Following local / specialty mortality review group discussion and agreement the chair / Mortality Lead is asked to close the case on the Datix mortality module. Closing a case confirms that outcomes have been discussed and agreed by the local clinical team.

See Appendix 1 for example of specialty mortality review group terms of reference

8.7. DIVISIONAL MORTALITY REVIEW GROUP

Every case with identified suboptimal care should be discussed at the associated Divisional Mortality Review Group, these meetings should:
- Be chaired by the Divisional Medical Director or Clinical Director
- Attended by Morality Leads from each Specialty (or representatives)
- Be promoted to senior Medical, Nursing and Allied Healthcare Professionals linked to the Division
- Meet monthly

The purpose of the Divisional Mortality Review Group is to:
- Monitor mortality review process compliance across the Division
- Discuss trend, actions and learning from mortality review
- Consider in detail all cases where suboptimal care has been identified
- 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

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

8.8. MORTALITY SURVEILLANCE GROUP

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
- Oversee the Divisional Mortality Review Groups' processes and actions
- 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 (i.e. Dr Foster)
- Consider reports and escalations from the Divisional Mortality Review Groups
- Support cross Divisional learning from death
- Ensure all cases graded as CESDI 2 / 3 have been resulted in Serious Incident Investigation

9. LAUNCHING SERIOUS 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 will be launched under the serious incident investigation process. See the 'Incident Reporting, Investigation and Management Policy' for details relating to the management of serious 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

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 to the local / specialty mortality review group when the case is scheduled for discuss by the Specialty Mortality Lead

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

Case reviewers are asked to identify patients with known / previously diagnosed significant mental health disorders within the standard mortality review form. Trends relating to this cohort of patients will be considered by the Mortality Surveillance Group. NHS England is coordinating work to develop a mental health review methodology and supporting national guidance; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

10.3. INFANT AND CHILD DEATHS

Reviews of infant and child (under 18 years old) deaths are mandatory and must be undertaken in accordance with the 'Working together to safeguard children' guidance. New national child death review guidance is being developed and is scheduled to be published by the end of 2017; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

10.4. PERINATAL DEATHS

The Perinatal Mortality Review Tool (PMRT) is being developed by the Healthcare Quality Improvement Partnership (HQIP) and national guidance for standardised perinatal review is scheduled for publication by the end of 2017; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

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 case record review
- 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

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

Staff will be supported to undertake mortality case review through the provision of further guidance on process, content of review and use of the Datix system. Specialty Mortality Leads will support members of their team produce quality reviews.

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**
Logging of all in-hospital deaths to Datix	Comparison of Datix mortality module with PAS	Safety Learning Programme Manager	Monthly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)
Case review process compliance	Report re timeframes for mortality case review completion	Safety Learning Programme Manager	Monthly	Divisional Mortality Review Group (DMRG)	Mortality Surveillance Group (MSG)

Grading of cases	Audit of cases with CESDI grade 0	Junior Doctor audit programme	Quarterly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)
Serious Incident declaration	Comparison of CESDI grade 2 / 3 mortality reviews in with declared Serious Incidents	Safety Learning Programme Manager	Quarterly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)

14. References

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 – Local / Specialty Mortality Review Group Terms of Reference (example)

Specialty Mortality Review Group

Terms of Reference

1. Constitution

The ***[INSERT NAME OF SPECIALTY]*** Specialty Mortality Review Group is established as a sub-group of the Divisional Mortality Review Group which reports to the Mortality Surveillance Group.

2. Authority

The Specialty Mortality Review Group is accountable to the Divisional Mortality Review 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);

3. Aim

The aim of the Specialty Mortality Review Group is to provide local senior clinical scrutiny to mortality review and to driving quality improvement by using a systematic approach to mortality review.

4. Objectives

Specific duties of the Specialty Mortality Review Group include:

- To provide a forum for open discussion of issues, outcomes, improvements and learning following mortality review.
- To ensure all deaths aligned to the Specialty are reviewed by the consultant / clinical team responsible for the patient (retrospective case review)
- To ensure all deaths aligned to the specialty are presented / discussed at the Specialty Mortality Review Group
- To agree the CESDI / Outcome grades for all deaths aligned to the Specialty
- To escalate identified issues, themes or notable learning to the Divisional Mortality Review Group
- To ensure suboptimal care or avoidable death identified through mortality review is recorded and investigated within the incident reporting system
- To provide assurance to the Divisional Mortality Review Group on all areas of its function

5. Method of working and monitoring effectiveness

The Divisional Mortality Review Group will have a standard agenda

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

The Group will receive regular Specialty mortality reports using the Datix Mortality Module as the reporting tool.

6. Membership

The Members of the Specialty Mortality Review Group shall comprise:

- Service Director / Lead (Chair)
- Consultants aligned to Specialty
- Nursing team representative

To foster leadership, learning and open communicate invitations are to be extended to all Junior Doctors aligned to the Specialty.

Meetings of the Specialty Mortality Review Group shall not be held in public.

7. Quorum

The quorum shall be 3 members, to include the chair or a deputy and 2 Consultants aligned to the Specialty.

8. Nominated Deputies

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

9. Frequency of meetings

The Divisional Mortality Review Group will meet **[WEEKLY/BI-WEEKLY/MONTHLY – FREQUENCY TO BE NO LESS THAN 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

Agenda are to be circulated by ***[ENTER JOB TITLE]***

11. Review process

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

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

Appendix 2 – Divisional Mortality Review Group Terms of Reference (example)

Divisional Mortality Review Group

Terms of Reference

12. Constitution

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

13. Authority

The Divisional Mortality Review 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.

14. Aim

The aim of the Divisional Mortality Review 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.

15. Objectives

Specific duties of the Mortality Review Group include:

- To oversee the Specialty Mortality Review processes
- To ensure all deaths aligned to the Division are reviewed at Specialty Mortality Review Groups
- To ensure all deaths aligned to the Division with identified sub-optimal care are presented / discussed at the Divisional Mortality Review Group
- To act on issue 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

16. Method of working and monitoring effectiveness

The Divisional Mortality Review Group will have a standard agenda

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

The Group will receive regular Divisional mortality reports using the Datix Mortality dashboard as the reporting tool.

17. Membership

The Members of the Divisional Mortality Review Group shall comprise:

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

To foster learning and open communicate invitations are to be extended to all doctors aligned to the Division, safeguarding and learning disability team representatives.

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

18. 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.

19. Nominated Deputies

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

20. Frequency of meetings

The Divisional Mortality Review 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.

21. Secretariat

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

22. 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 3 - outline of the National Learning Disabilities Mortality Review (LeDeR) process