York Teaching Hospital NHS
NHS Foundation Trust

Learning from Deaths Policy

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Owner:	Medical Director
Publisher:	Medical Governance
Version:	1
Date of version issue:	September 2017
Approved by:	Executive Board
Date approved:	September 2017
Review date:	September 2018
Target audience:	All clinical staff
Relevant Regulations and Standards	National Quality Board guidance
Links to Organisational/Service Objectives, business plans or strategies	
Executive Summary This policy describes the process by which the Trust learns from mortality reviews and how the Board will be informed of the learning.	

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Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1	September 2017	Peter Wanklyn, Helen Noble	Staff Room	

Contents

1.   Introduction

Mortality data from each NHS Trust is freely available in the public domain, and comparisons in rates between Trusts are made and used as part of the overall assessment of the quality of care provided. The Keogh review (2013) examined the quality of care and treatment provided by 14 NHS Trusts that had shown persistently high mortality rates over the previous two years, and as a result of the findings the 14 Trusts were put into "special measures" by Monitor.

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017, the CQC set out new requirements for the investigation of deaths for all Trusts to run alongside the local existing processes. This was followed by the publication by the National Quality Board in March 2017 providing further guidance for Trusts entitled 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. This policy relates to all patients aged 18 or more who die in hospital.

The Trust has investigated deaths since 2013 through the use of a structured proforma, in addition to the formal investigation of deaths reported through the incident management process.

Investigations of all maternal, still birth and neonatal deaths have been carried out for a significantly longer period.

2.   Purpose

The purpose of this policy is to describe the process by which we learn from mortality reviews and how we will keep the Board informed of the learning. This will enable us to identify areas for improvements in patient care and experience. It will also allow us to take action to reduce the mortality rate at the Trust and, where death is inevitable, to ensure the highest possible quality of care is delivered.

The policy will ensure that there is a consistent and coordinated approach to undertaking mortality reviews, and reporting on findings, with implementation of identified actions. It will also clarify how the process for mortality review dovetails with other investigation processes within the Trust. This will facilitate a streamlined and coordinated interface with incident, complaint, inquest and claims investigations, where applicable.

Completion of timely and proportionate mortality reviews will also enable the Trust to identify recurring and emerging issues and to be able to respond quickly to any questions raised by external organisations, e.g. CCG, CQC, in relation to mortality trends.

3.   Definitions

The definitions or explanation of terms relating to this document are:

SHMI   Summary Hospital-level Mortality Indicator is published quarterly by the Department of Health. It is calculated in a similar way to HSMR, but includes deaths in all clinical classifications, and also deaths occurring up to 30 days after discharge.

4. Duties (Roles and Responsibilities)

Duties within the Organisation

The Board of Directors will keep the learning from death process under constant review. It will receive reports relating to mortality review findings, and request additional reviews and actions as a result.

The Medical Director has executive responsibility for the mortality review process and implementation of improvements. Operational responsibility for the mortality review programme, including reporting its findings and implementing improvements, is delegated to the **Clinical Lead.**

The nominated Non-Executive Director has responsibility for scrutinising the Trust's process for learning from deaths in hospital and gaining assurance that themes are detected and lessons learnt to prevent recurrence.

The Coding Team will ensure that the patient's care is coded as soon as possible, ideally within seven working days of the patient's death. The notes will then be returned to the responsible Consultant without delay.

Systems and Networks will review local data sources and national benchmarking tools, i.e. SHMI provided by the Healthcare Evaluation Data (HED), and additional information provided by NHS Digital for early warning signs. Any areas of concern will be flagged to the Clinical Lead who will initiate a coordinated and proportionate investigation.

Bereavement staff will provide information (including the booklet which explains the mortality review process) and support. They will also determine whether the bereaved have any concerns about the care delivered. If so, they will escalate it to their manager who will decide if an SJCR is required and contact the patient safety team.

Individual Consultants responsible for care will complete the initial mortality review within a week of receiving the notes. They will indicate if there were significant problems in care using the overall care score and indicate whether a structured judgement casenote review (SJCR) is required. If necessary, they will meet the bereaved to explain the investigation report and what action will be taken to reduce recurrence risk.

Clinical Governance leads will all receive training in the SJCR methodology and ensure an adequate number of colleagues in their specialty have also done so. They will evaluate the initial reviews and commission an appropriate level of investigation and inform the Patient Safety team who will coordinate the process. They will ensure that support is provided to colleagues in communicating the report to the bereaved if that is required. They will ensure all SJCRs are discussed in the directorate governance meeting and the action plan is agreed and implemented. They will also produce a quarterly report of the SJCRs which have occurred in their directorate and what action has ensued.

Mortality Reviewers will complete and return SJCRs within 2 weeks using the NMCRR data capture form. This may be available on a web-based datix platform in the future. They will also produce an action plan based on the themes identified. Reviewers must flag any difficulties in undertaking reviews to the Patient Safety Team. If the bereaved wish to receive further information, they will produce a summary of the SJCR findings.

Directorate managers/Clinical Directors will provide support to colleagues if poor care is identified. Assistance may be needed for meetings with the bereaved in some cases. They will also analyse and help address any recurrent poor care themes within the directorate.

The Patient Safety Team will coordinate the mortality review process, maintaining an up-to-date spreadsheet of reviewers and cases, and ensuring that cases are allocated appropriately. They will provide information and ongoing support for the bereaved during the SJCR process and arrange meetings and written communication. They will ensure the GP has been informed of the SJCR outcome in cases with poor overall care or avoidable death.

The team will review and analyse the results of mortality reviews and, together with the Clinical Lead, produce a quarterly report of findings for the Board of Directors.

5. Process for conducting mortality reviews

5.1 Reviews of individual patients

Learning from individual deaths will be performed using an initial screening review proforma followed, in some cases, by a more detailed retrospective structured judgement case note review (SJCR). Some deaths will automatically trigger a SJCR independent of the initial review.

A standard operating procedure has been developed to ensure standardisation of the process (appendix 1).

5.1.1 Initial screening review

All deaths in hospital will be reviewed by the responsible Consultant using a screening mortality review proforma. The aim of this screening review is to establish whether the care delivered was timely and according to current best practice.

The reviewer will be required to provide an overall score for the quality of the care provided on a scale of 1 to 5 as below (Royal College of Physicians 2016)

1 Very poor care
2 Poor care
3 Adequate care
4 Good care
5 Excellent care

The reviewers will be asked whether any harm occurred from omissions or actions in care delivered which impacted on the patient's death for example a patient fall or medication error with harm. If harm is observed from the review this should be reported, if not done already, on Datix. In addition, the Consultant should consider whether there was any evidence of a need to report as a possible SI at this point.

5.1.2 Follow-up / escalation following screening

The process following the initial screening review is managed according to the overall quality of care score as outlined in the flowchart in Appendix 2

Cases where the care is assessed as adequate, good or excellent and there was no harm related to the patient's death will result in no additional investigation unless raised through the mandatory review triggers, request from an external agency or the complaints process.

Cases where harm was noted relating to care or the overall care was assessed as poor or very poor will be subject to a SJCR. This will be commissioned by the directorate governance lead who will inform the patient safety team.

5.1.3 Structured judgement reviews

The SJCR will be performed by a clinician specially trained in the methodology using the Royal College of Physicians programme. Cases will be identified from initial screening but the following categories of case are mandated to receive a SJCR (although this list is not exhaustive, see flowchart appendix 2)

- Deaths where families have raised a significant concern about the quality of care provision
- All deaths of patients with Learning Disabilities (in conjunction with the LeDeR process), or significant mental health conditions
- Deaths following elective procedures

Consideration will also be given to the following deaths:

- SHMI alerts or condition specific outliers
- Random samples of specific groups or conditions
- Cases where death was not expected
- Deaths where the learning will inform improvement work
- Incidents with harm
- Cases going to coroner's inquest
- Claims
- Child, still born and perinatal and maternal deaths (in conjunction with the existing review processes)

In cases flagged for a mandatory SJCR, the Patient Safety Team will allocate the case to a reviewer who is independent from the direct care of the patient. SJCRs should be completed within two weeks of allocation.

All completed SJCRs will be returned to the Patient Safety Team for thematic analysis and will be recorded on a database.

Cases given an overall care score of 1 - 2 with harm caused will be reported on Datix and referred to the weekly serious incident (SI) panel to agree the level of further investigation. This will usually be either to refer for investigation, root cause analysis and action planning by the directorate or to investigate as an SI. (see escalation flowchart – appendix 2).

Cases given an overall care score of 3 or more but with a care score in any phase of 1 or 2 and harm caused will be reported on Datix and returned for action by the directorate through the governance lead (see escalation flowchart – appendix 2).

Any cases with all care scores of 3 or more will not require further action but will be returned for discussion by the directorate through the governance lead.

5.2 Family and carer involvement

Bereavement office staff will enquire if the bereaved have any concerns about the care provided and escalate to their manager as required. Bereaved families and carers will be informed about the Trust process for Learning from death in the Bereavement information booklet. If a SJCR is commissioned, they will be informed and invited to be involved with the review and offered a summary of the report (appendix 6). They must be dealt with respect, sensitivity and compassion and should be treated as partners in an investigation, if they so wish, as they can offer a unique and equally valid source of information.

All deaths reported as serious incidents will be communicated to the bereaved family or carer as part of the duty of candour requirements and they will have the opportunity to have their concerns investigated. Further details are covered in the Being open with patients policy.

Bereaved family and carers who choose to make formal complaints will have their concerns investigated and this will include a mortality review. This is included in the concerns and complaints policy and procedure available on the intranet.

5.3 Reviews of clusters of cases as a result of alerts / horizon-scanning

5.3.1 Identification of cases

Systems and Networks with Patient Safety Team will monitor for early indications that mortality is rising in a specific clinical classification area.

Findings will be discussed at the MSG to determine appropriate action. This may include commissioning a review of a small sample of SJCR's on these clinical cases. This process will involve the relevant directorate from the outset.

5.3.2 Scope of review

The informatics team will notify the Medical Director via the MSG with relevant information regarding alerts. The MSG will agree the level of review, terms of reference, sample size and time frames.

5.4 External Mortality Reviews

5.4.1 Child deaths

Deaths of all children from birth to 18 years in the area are notified to the Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP) including children in our care. Whilst all deaths are notified to the JCDOP and a core data set collected, not all deaths will be reviewed in detail. Particular consideration shall be given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. The team will determine and review on a regular basis which deaths are to be reviewed in an in-depth manner using the SJCR methodology or as a SI.

5.4.2 Maternal deaths

All maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports will be presented to the MSG.

(Further information can be found in the Maternal Death Guidelines.

5.4.3 Still born and Perinatal deaths

All still born and perinatal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. These cases are also reported on DATIX to ensure local governance and risk management structures are followed. Each case is subjected to a 1st and 2 level review process using the NPSA review proforma. Quarterly reports will be presented to the MSG.

(Further information can be found in the Care of women and families experiencing the death of a baby).

5.4.4 Learning Disabilities Mortality Review Programme (LeDer)

The LeDeR Programme is run by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to make improvements in the quality of health and social care for people with learning disabilities, and to reduce premature deaths in this population.

LeDeR will support local areas in England to review the deaths of people with learning disabilities aged 4 – 75 at the time of their death. All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process will run alongside our internal mortality reviews and will not replace out internal process. See appendix 3 for LeDeR reporting process.

6. Reporting of findings

6.1 Datix reporting

If the SJCR gives an overall care score of 1-2 with harm caused it will be reported on Datix and escalated to the Serious Incident Panel to determine the level of further investigation.

In addition, any mortality case review where an incident resulting in harm has been identified should be reported on Datix.

All other cases will be reviewed and actioned by the directorate through the governance lead.

6.2 Learning from Death Reports

6.2.1 The Patient Safety Team, with the Clinical Lead, will produce a quarterly report of trust-wide mortality review findings which will be presented to the Board. These reports will include;

- The total number of deaths and the number of mortality reviews performed
- How many deaths were judged to have overall poor care
- Themes and trends arising from the reviewed cases
- A summary of the key findings of cases with either poor or very poor care
- Any learning points, recommendations and actions
- Assurance that action plans and the Duty of Candour process have been completed

The report is to be presented to the Mortality Steering Group (MSG), Directorate Governance Meetings, and the findings escalated to the Quality and Safety Committee as appropriate.

6.2.2 Findings of "cluster reviews" will be presented to the MSG, and shared with the relevant directorate who will be responsible for delivering an appropriate action plan. The MSG will continue to monitor mortality within that speciality/condition to ensure improvement is seen.

6.3 Action planning and learning

The MSG will approve any recommendations identified in the quarterly report, and any action plan including timescales and action owners.

The Patient Safety Team will ensure the action plan is circulated to the action owners, and will monitor progress and completion, which will be included in the ensuing reports.

Opportunities for learning will be delivered through newsletters, clinical governance meetings and patient safety events.

6.4 Real time data

A folder has been developed on the Trust Q drive called "SJCR in depth reviews". There are sections for investigation tools, completed reports, reviewers training and a database of ongoing reviews.

7. Training and Implementation

Training for initial screening Reviewers: all Consultants have been offered training in the SJCR methodology. In addition a brief summary sheet has been developed to guide assessing care standards and scoring for those who have not been able to attend. Short sessions in Clinical governance meetings will be provided. Staff who are experiencing difficulties eg in forming conclusions from their reviews, may seek advice and support from a reviewer colleague, or from the Clinical Lead.

Training for Structured judgement reviews: this training will be provided by staff who have already received training from the Improvement Academy in the RCP programme.

Implementation: Upon ratification, this document will be available to all staff via the Guidelines page on the Trust's Intranet. The ratification of the document will also be communicated to staff via Directorate communication routes.

8.   Trust Equalities Statement

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

9.   Monitoring Compliance

Compliance with this process will be evaluated from the quarterly mortality reports, which will include a section on process and performance, as well as findings.

10. Associated Documents

This document should be read in conjunction with the Serious incidents (SI's) policy and procedure.

11. References

This document was drafted with reference to the following documentation:

CQC (2016) *Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England* http://www.cqc.org.uk/content/learning-candour-and-accountability

Hogan et al (2012) *Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.* BMJ Quality & Safety 22 (2): 182

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf*

NHS England (2017) *National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Royal College of Physicians (2016) *National Mortality Case Record Review Programme. Using the structured judgement review method. A guide for reviewers (England)*

https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

Parliamentary and Health service Ombudsman (2016) Learning from mistakes https://www.ombudsman.org.uk/sites/default/files/page/Learning%20from%20mistakes%20-20An%20investigation%20report%20by%20PHSO.pdf

Appendix 1: SOP for mortality reviews
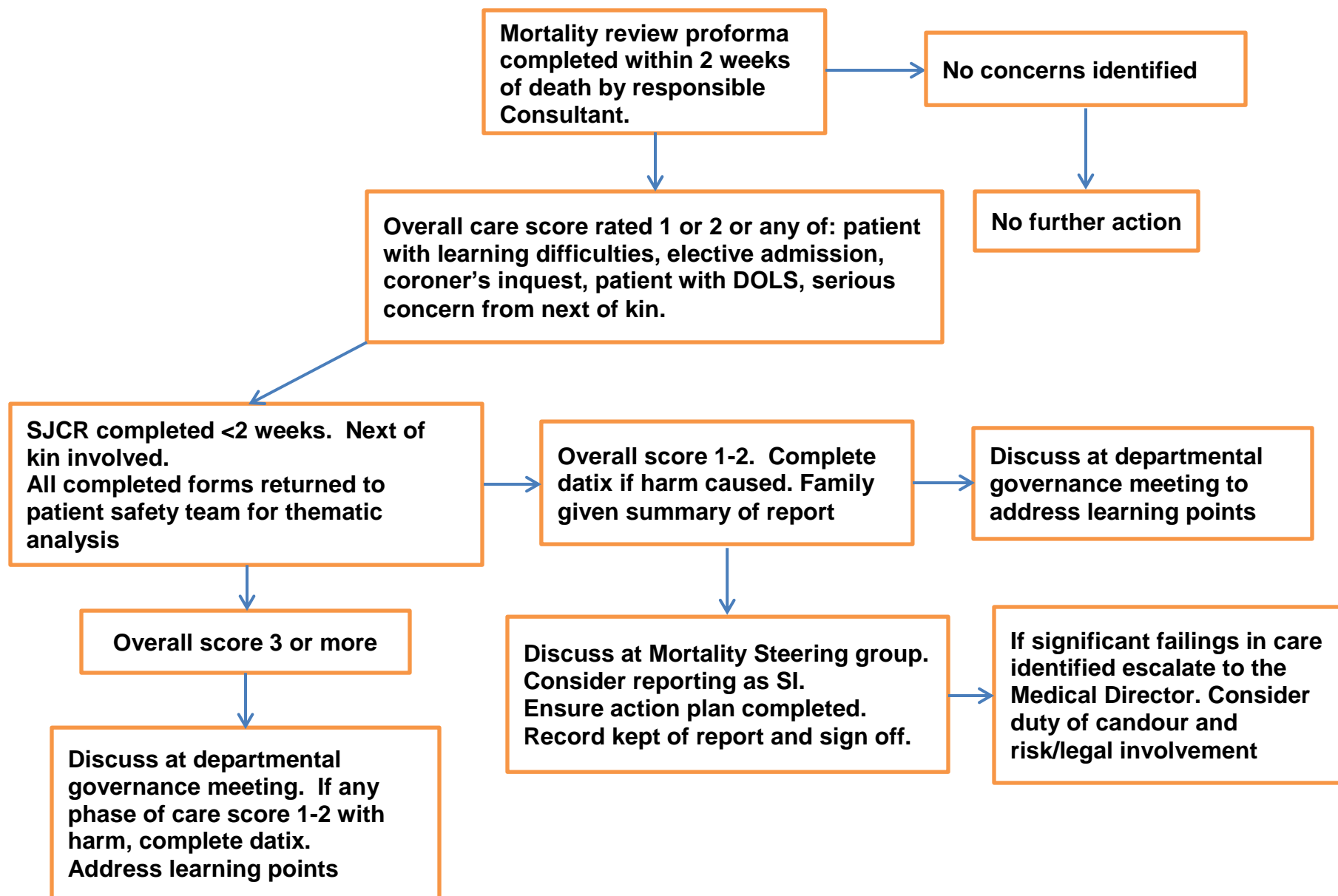
Purpose

The purpose of this SOP is to define the two stage process by which mortality reviews are completed. This is part of the trust's 'Learning from Deaths' policy. This SOP applies to mortality reviews in all specialties:

Agreed Procedure

- All patients who die in hospital will have an initial screening review performed by the responsible Consultant.

- Deaths which occur on ICU will have an initial review by the responsible Consultant (physician or surgeon) and an ICU consultant. This is because both are involved in delivering care so both perspectives need to be considered.

- It is expected that the initial reviews will be completed within two weeks of the patient's death using the Trust proforma.

- Any reviews with an overall care rating of either 1 or 2 will trigger a second level review called a structured judgement casenote review or SJCR.

- The responsible Consultant should also note the cases triggering a mandatory SJCR and indicate this on the form which is returned to the directorate governance lead.

- Once a case is identified for a SJCR the Patient Safety team will be informed by the directorate governance lead and will send a letter stating that an investigation is ongoing (appendix 6).

- The Patient Safety team may also identify mandatory cases for SJCR from other information sources e.g. concerns expressed to bereavement office staff, and the responsible consultant and directorate governance lead will be informed in these cases.

- A SJCR will be commissioned by the directorate governance lead or Patient Safety team. For further information contact Dr P. Wanklyn, Learning from deaths Lead or Helen Noble, Head of Patient Safety.

- SJCRs must be undertaken by a clinician trained in the methodology and be independent of the responsible consultant. The reviewer will usually be from the same specialty but this is not essential.

- SJCRs should be completed within 2 weeks of allocation and all sent to the patient safety team for collation and thematic analysis.

- The bereaved will receive a summary of the SJCR report if they wish. This will be clear and avoid jargon. The overall context and implications of any poor care will be explained and the actions planned to reduce recurrence should be outlined.

- Any SJCR with an overall score of 1 or 2 will be discussed at the MSG. If harm was caused by identified poor care a datix will be completed. In this situation, the case will be reported as a possible SI. If serious failings are identified, the Medical Director will be made aware at that point.

- Any review with an overall care score of 3 or more will be discussed at the directorate governance meeting to scrutinise any themes of good or poor care and produce an action plan. If any single phase of care scored 1 or 2 and harm occurred, a datix will be completed.

- Deaths which occur in the Emergency Department will be investigated using the same methodology.

- In cases where an SI is declared, the investigation will follow the Trust's policy. The clinical review will utilise the SJCR methodology so all SI investigators need training in this process. In cases where the investigator has yet to complete the training, the mortality clinical lead will perform the SJCR component of the investigation.

- Each directorate governance lead will submit the cumulative findings from reviews in that specialty to the MSG every three months. This should include progress on any specific actions or learning from reviews. This will be integrated into the quarterly mortality dashboard.

Appendix 2: Mortality Review Process

York Teaching Hospital **NHS**
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Mortality review proforma completed within 2 weeks of death by responsible Consultant. → **No concerns identified**

↓

Overall care score rated 1 or 2 or any of: patient with learning difficulties, elective admission, coroner's inquest, patient with DOLS, serious concern from next of kin.

No further action

↓

SJCR completed <2 weeks. Next of kin involved. All completed forms returned to patient safety team for thematic analysis → **Overall score 1-2. Complete datix if harm caused. Family given summary of report** → **Discuss at departmental governance meeting to address learning points**

↓

Overall score 3 or more

↓

Discuss at departmental governance meeting. If any phase of care score 1-2 with harm, complete datix. Address learning points

Discuss at Mortality Steering group. Consider reporting as SI. Ensure action plan completed. Record kept of report and sign off. → **If significant failings in care identified escalate to the Medical Director. Consider duty of candour and risk/legal involvement**

Appendix 3: Leder Programme

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┌─────────────────────────────┐
│   Trust Nominated Contact    │
│    reviews Death List on     │
│         weekly basis         │
└─────────────────────────────┘
              │
              ▼
┌─────────────────────────────────────────────────────┐
│ Where patient with learning disabilities aged        │
│ between 4 -74 is identified, notification is made    │
│ either:                                              │
│                                                      │
│   1)  Telephone : 0300 777 4774                      │
│   2)  Via website on                                 │
│       http://www.bristol.ac.uk/sps/leder/notify-a-death/ │
└─────────────────────────────────────────────────────┘
        │                              │
        ▼                              ▼
┌──────────────────┐          ┌──────────────────────┐
│   Trust Action   │          │ Leder Programme      │
│                  │          │ Action               │
└──────────────────┘          └──────────────────────┘
        │                              │
        ▼                              ▼
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Trust Nominated Contact escalates as follows:
1) Immediate Notification to Chief Nurse and Director of Patient Safety
2) Contribute to Leder Multi-Agency Review Meeting
3) Commitment to Any concluding Action Planning
4) Data base completion
5) Quarterly Reporting to Safeguarding Adult Governance Group

National Leder team receives notification

Local Area Contact(LAC) informed and nominates local reviewer

Local reviewer Action:
1) Idenitifes if any other reviews being conducted (SCR, DH, CDOP, Internal reviews). Links with these reviews
2) Contact family
3) Creates Pen Portrait
4) Decides on further action

Further Review:
1) Multi-Agency Meeting convened.
2) Agree contributory factors if any
3) Identify lessons learned if any
4) Agree good practice and recommendations
5) Complete and cascade action plan
6) Summary to Leder Programme for sign off and close

No Further Action

Appendix 4: Care Review – Bereavement Information

The Trust has a fundamental obligation to be open and honest in the event of an incident where patient harm has occurred. **ALL** moderate and severe harms must be handled and reported under Being Open, the pivotal feature of which is early acknowledgement, explanation and apology.
All NHS Trusts are now required to review the care of people who have died in hospital. The reason for this is to ensure we learn more about the circumstances and manner of the death. We want learn from any good practice or to identify and improve upon any examples of poor care.

Please do let the Bereavement team know if you have any concerns about any aspects of care during the last hospital admission.

The Consultant looking after your relative /friend will examine the care records and judge whether anything could have been done more effectively. On the rare occasions this is so, another independent Consultant will perform a detailed review of the medical notes and decide if care was adequate or not. They will make recommendations on how to avoid it happening again. We shall inform you if this is going ahead and will ask you to comment on the draft report if you wish.

There are some patient groups whose death has to be investigated in detail by an independent Consultant. These groups are: young children, pregnant women, those with learning difficulties, those whose family have serious concern about the care provided, and those who deteriorated unexpectedly or in some cases where an inquest is held.

In the large majority of cases, care is very good and no concerns are raised.

If there are concerns raised, we shall contact you to give you a named contact and contact number. If good practice standards were not met we shall offer to discuss this with you and explain what we shall do about the problem.

We apologise if this causes distress but we believe in continuous improvement and being open as an organisation.

Appendix 5: Mortality Steering Group Terms of Reference

York Teaching Hospital **NHS**
NHS Foundation Trust

Mortality Steering Group
Terms of Reference
1. Membership
Medical Director- Chair Consultant Physician /Lead for Mortality– Vice Chair Head of Patient Safety Anaesthetist Acute Physician Doctor- Care of the Elderly Doctor- General Surgery Junior Doctor representation Lead for Critical Outreach Information Department Representation On the occasions when a member is unable to attend it is important that a deputy is nominated to attend who will form part of the quoracy. The Deputy Medical Director and Consultant Physician /Lead for Mortality will share the Chair and Vice Chair of the Committee.
2. Quoracy
The group will be quorate with four members of the group in attendance plus the Chair, if the Chair is unable to attend the meeting the Deputy Chair or Vice Chair will deputise on behalf of the Chair. The group must include the following members (one nurse, two doctors and a member of the Patient Safety team).
3.Purpose of the Committee-Operational functions:
- To work towards the elimination of all avoidable in-hospital harm and mortality.   - To review on a monthly basis, the benchmarked mortality rates of the Trust.   - To facilitate and consider mortality data in conjunction with clinical data and identify areas for future investigations.   - To investigate any alerts received or identified e.g. CQC, SHMI.   - To assign clinical leads to address raised mortality in particular clinical areas with the implementation of strong evidence based interventions such as care bundles.   - To work with each junior doctor intake to ensure the latest guidelines on care protocol implementation and clinical coding best practice.   - To review and monitor compliance with other Hospital policies including DNACPR/ Ceiling of care/ End of life care and Death Certification.   - To monitor and consider the information from review of all in hospital deaths.

4.Strategic Functions:

- To act as the strategic hospital mortality overview group with senior leadership and support to ensure the reduction of all avoidable deaths.
- To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training etc. This will be reviewed on an annual basis by the Medical Director.
- Sign off action plans and methodologies that are designed to reduce morbidity and mortality across the Trust.
- Sign off all regulatory mortality responses.
- To report on Mortality performance to the Board.

5. Meeting arrangements

The Mortality Steering Group will meet monthly and all supporting papers will be circulated 7 days in advance of the meeting.

The Chair of the Mortality Steering Group has the right to convene additional meetings should the need arise and in the event of a request being received from at least 2 members of the Group.

Where members of the Mortality Steering Group are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the Medical Director and provide a deputy in order that the meeting of the Group can be quorate.

6.Review and monitoring

The Head of Patient Safety will maintain a register of attendance at the meeting. Attendance of less than 50% will be considered inadequate and escalated to the Medical Director, who will decide what action may be taken. The attendance record will be reported as part of the annual report to the Patient Safety Group. The Terms of Reference will be reviewed every 2 years.

Author	**Helen Noble – Head of Patient Safety (Scarborough)**
Owner	**Jim Taylor – Medical Director**
Date of issue	**July 2017**
Version	**V1**
Approved by	**Mortality Steering Group**

Appendix 6: Form letter for Bereaved Families Regarding Structured Judgement Casenote Reviews

Dear XXX

As a Trust we believe in being open and learning continuously how to improve services. As part of this we examine the casenotes of all patients who have died in hospital to see if there is anything that we can do better in the future. This is a national requirement for all hospitals and is part of our routine practice.

In the case of, XXX, we have asked for an independent Consultant to have a look at the notes to provide an opinion whether the care was delivered to the highest possible standards at all times. We are looking for things which are done really well to spread good ideas and care, and if there is anything that we think we can improve upon, the report will note it and we will take action.

If you wish to be involved with this review before it is completed please contact us. You can also have a summary of the final report if you wish.

The contact point for the Patient Safety Team who coordinate this work is 01904 723221.

Support is available from the Bereavement Office at York (01904 725445) or at Scarborough Hospitals (01723385178) and also from the PALS staff on 01904 724020.

Yours sincerely

Dr Peter Wanklyn – Consultant Physician
Helen Noble – Head of Patient Safety

Appendix 7: Policy Management

1   Consultation Process

Consultation has taken place with both the Mortality Steering Group and the Patient Safety Committee.

2   Quality Assurance Process

The author has consulted with the following to ensure that the document is robust and accurate:-

- Clinical Director Paediatrics
- Clinical Director Obstetrics
- LeDeR/Safeguarding Lead

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

3   Approval Process

The approval process for this policy complies with that detailed in the Policy Guidance.

4   Review and Revision Arrangements

The authors will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent reviews of this policy will continue to require the approval of the Executive Board.

5   Dissemination and Implementation

Dissemination and implementation will comply with the process detailed in the Policy Guidance document.

6   Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

Please refer to the Policy Development Guideline for detail.

7   Standards/Key Performance Indicators

- National Quality Board Guidance

8   Training

See Section 7 of this Policy.

9   Trust Associated Documentation

- Serious Incident Policy & Procedure

10   External References

See Section 11 of this Policy.

11 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Process & performance	Quarterly Monitoring reports	Mortality Steering Group, Patient Safety Committee	Quarterly	Mortality Steering Group, Patient Safety Committee	Mortality Steering Group, Patient Safety Committee	Mortality Steering Group, Patient Safety Committee

Appendix 8: Dissemination and Implementation Plan

Title of document:	Learning from Deaths
Date finalised:	September 2017
Previous document in use?	Yes
Dissemination lead	Patient Safety
Implementation lead	Patient Safety
Which Strategy does it relate to?	

Dissemination Plan	
Method(s) of dissemination	Staff Room
Who will do this	Policy Manager
Date of dissemination	September 2017
Format (i.e. paper or electronic)	Electronic
Implementation Plan	
Name of individual with responsibility for operational implementation, monitoring etc	Patient Safety Lead
Brief description of evidence to be collated to demonstrate compliance	