Imperial College Healthcare NHS Trust

Trust-Wide Policy

Learning from Deaths Policy

Key Points:

This is a controlled document. Whilst this document may be printed, the electronic version uploaded on the intranet is the controlled copy and printing is not advised. This document must not be saved onto local or network drives but must always be accessed from the intranet.

All employees must adhere to the requirements set out within this document. Any specific responsibilities or actions for particular staff or staff groups will be outlined within the main body of the document and their duties cascaded to them as required.

Promoting equality and addressing health inequalities are at the heart of Imperial College Healthcare NHS Trust's values. Throughout the processes detailed within this document the Trust has given due regard to the need to eliminate discrimination, harassment and victimisation to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic, as cited under the Equality Act 2010, and those who do not.

The Quick Reference Guide for this document is located as Appendix 1.

Current Document Status:	Final.

Contents

1. Introduction

1.1 Imperial College Healthcare NHS Trust (ICHT) is committed to promoting and providing services that meet the needs of individuals and does not discriminate against any employee, patient or visitor that may relate to any of the protected characteristics under the Equality Act 2010. The equality analysis for this Policy is held by the Head of Trust Policy Management.

1.2 The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trust and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. The First Edition was released in March 2017. One of the regulations set out in this guidance (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." This policy closely follows the detailed guidance set out in Annex C. NHS Improvement and the Care Quality Commission stipulate that the Responding to Deaths Policy should be approved and in place in Trusts by September 2017.

2. Purpose

2.1 The purpose of the Learning from Deaths Policy is to describe the process by which all deaths in care are identified, reported and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. It seeks to ensure the Trust engages meaningfully and compassionately with bereaved families and carers and supports staff to find all opportunities to improve the care the NHS offers by learning from deaths.

2.2 For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

3. Roles & Responsibilities

3.1 **Board of Directors** is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

3.2 **Chief Executive** has overall responsibility and final accountability for ensuring that the Trust has appropriate mortality review procedures in place; and that the Trust works to best practice as defined by relevant regulatory bodies.

3.3 **Medical Director** has been designated as the Lead Board member with responsibility for mortality review procedures, and as such will ensure that a robust system is in place which provides collated Trust level data on mortality

rates, reviews of deaths, avoidable mortality rates and actions taken to address deficiencies in care and/or processes.

3.4 **Associate Medical Director (Safety & Effectiveness)** has responsibility for:

- Overall assurance that the mortality review process is in line with national standards
- Is responsible for assuring the MD that the divisional processes are in line with the policy
- Is responsible for statutory reporting in line with national policy, including to the annual Quality Account
- Management and Chair of the Mortality Review Group
- Ensuring that each division has an adequate number of investigators and that they are adequately trained in the methodology of Structured Judgement Review (SJR)

3.5 **Head of Quality Compliance and Assurance** is responsible for ensuring the reporting systems are fit for purpose and for ensuring that the milestones to deliver the policy are regularly monitored and reported, and for ensuring data is available for necessary reporting

3.6 **Divisional Triumvirate** is responsible for ensuring the policy is implemented throughout the Divisions and Directorates, including identifying and supporting the required number of investigators for deaths selected for SJR. They are responsible for monitoring compliance with the policy and for ensuring structures are in place within clinical services to review deaths in accordance with this policy.

3.7 **Divisional Governance Leads** are responsible for reporting divisional mortality data and performance to local governance forums, as well as escalating identified issues to the Mortality Review Group. They are required to liaise with families to ensure any outstanding concerns the family have raised are addressed within the context of their investigation and upon conclusion of the review, are able to discuss their findings and any learning's with the family.

3.8 **Head of Patient Affairs Service** is responsible for ensuring mortality notification forms are completed in a manner and timescale defined within this policy.

3.9 **Patient Advice and Liaison Service (PALS)** is responsible for ensuring relatives that make contact with the service are appropriately managed in accordance with approved policies, and where appropriate identify where cases should be referred for Structured Judgement Review.

3.10 **Consultant staff** is responsible for the accurate completion of the mortality notification form in the Patient Affairs Office as part of the death certification process. They will review patient deaths in their service using the Datix mortality-screening tool (level 1 review) and identifying patients who require further review either through their M&M forum (level 2 review) or an independent Structured Judgement Review. 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.

3.11 **Corporate Mortality Auditor** is responsible for:

- Review reported mortality records and assign for Structured Judgement Review within the parameters of this policy
- Supplying mortality notification and mortality performance data to enable mortality reporting in accordance with this policy
- Alerting appropriate leads when actions are overdue and escalate where appropriate to the Head of Quality Compliance and Assurance
- To provide training and support of specialty teams in respect to M&M process, as well as to Structured Judgement Reviewers

3.12 **Structured Judgement Reviewers** are responsible for conducting independent, objective, case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams if required to ensure a high quality, comprehensive review is undertaken utilising the full range of medical records available to them. Where a death is deemed avoidable they will alert the division at the earliest opportunity so the case can be reported as an incident and reviewed at the weekly Medical Director Incident Review Panel (MD panel). The MD panel will consider the issues identified and decide whether it requires investigation under the SI framework.

3.13 **Mortality Review Group (MRG)** will receive divisional data via the divisional governance frameworks. It will oversee the mortality review process and report on the themes emerging for institutional learning. The MRG will sign-off the Trust quarterly mortality report before its review at Executive Committee for Quality (ExQu). Additional responsibilities of the MRG include:

- Investigation of any external mortality alerts received such as those received from Dr Foster, CRAB (Copeland's Risk Adjusted Barometer), and the Care Quality Commission (CQC).
- Review of benchmarked mortality data and initiation of further investigations into relevant external alerts.

The draft membership and Terms of Reference (ToR) of the mortality review group are included in Appendix 1.

ExQu will review all data submission prior to any external reporting.

4. The Process

All patients who die following admission to the any of the Trust's sites are regarded as 'deaths in care' and will be subject to this policy.

4.1 Certifications and Registration of Death

When a death occurs the consultant responsible for care (as either the "Attending Practitioner" or that doctor's supervisor) has a duty to decide whether the coroner needs to be informed and to oversee the process of completing the Medical Certificate of the Cause of Death (MCCD). The MCCD should be completed within 24 hours for all deaths as circumstances allow. The Patient Affairs Team will complete the Notification of Death Form (MM1) in the Patient Affairs Office at the time of completion of the death certificate (MCCD) or referral to Coroner.

4.2 Screening

When a death is logged to the system consultants registered to that specialty will receive an email alert. Screening (level 1 review) involves a suitable consultant providing a brief clinical review of the clinical episode. This is completed on Datix using a list of prompts. This may be the consultant

responsible for the care of the patient at the time of death, or a nominated consultant within that specialty. The consultant is required to assign an avoidability score. This score is taken from the Royal College of Physicians National Mortality Case Record Review Programme.

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Following this, the consultant is asked to select whether or not they feel that the death requires more in depth review. If the answer is yes, the case will undergo local specialty based multi-disciplinary Mortality and Morbidity (M&M) meeting (level 2 reviews). The consultant will also be offered an opportunity at this point to refer the case for Structured Judgement Review (SJR).

4.3 M&M Review

Clinical teams may choose to undertake specialty based multi-disciplinary Mortality and Morbidity (M&M) meeting (level 2 review) in any case they feel demonstrates an opportunity for reflection or learning. M&M reviews must be objective and multidisciplinary, and must involve at least one consultant not directly involved in the care of the patient. Where relevant, the input of senior clinicians from other relevant specialities should be invited.

A record of the level 2 mortality reviews must be entered to the case file on Datix. Records of this meeting and meeting attendees must be retained as evidence at divisional level. They may be added to the document repository within Datix to ensure evidence is available if required.

The Datix form (MM2) adopts a standardised approach to M&M discussion utilising the SBAR approach (Situation, Background, Analysis, Recommendations). The case review should conclude with a clear judgement of the avoidability of the death, and any learning points as a result of the review. If, following local M&M, any concerns are raised the clinical team have an opportunity at this point to refer the case for Structured Judgement Review (SJR). Learning from level 2 mortality reviews must be recorded on Datix and disseminated through appropriate clinical governance structures.

4.4 Structured Judgement Review

Structured Judgement Review is a validated methodology based on the principle that trained clinicians use explicit statements to comment on the quality of healthcare and that judgment is reproducible. Trained reviewers look at medical records in a critical manner and comment on specific phases of care. The purpose of the review is to provide information from which teams or the organisation can learn. The trust has a cohort of trained Structured Judgement Reviewers, across a range of specialty backgrounds.

The trust will undertake Structured Judgement Reviews in no less than 15% of hospital deaths. Any case may be referred for Structured Judgement Review, either at the discretion of the clinical team, because concerns have been raised, or because the case falls within pre-selected cohorts of patients as set out in this policy
These cohorts include:

- Any concerns have been raised by the bereaved family
- Any concerns have been raised by staff involved in the patients care
- First stage case record review suggests a more in-depth review may be helpful or where the death is judged to have greater than 50:50 chance of being preventable.
- A patient has a Learning Disability (in-line with the national LeDeR process)
- A patient detained under the Mental Health Act
- Any case that is subject to a Coroner's Inquest or enquiry
- Any case that is subject to a Serious Incident (SI) Investigation
- Deaths in patients aged between the ages of 16 and 25.
- Any mortality alert from Care Quality Commission, via benchmarking systems including the HES system (for SHMI and HSMR) or the CRAB Clinical Informatics system (we review any death identified with 4 or more medical triggers).

Structured Judgement Reviews must be undertaken in all identified cases meeting the criteria, and by staff specifically trained in Structured Judgement Review methodology. They must ensure all aspects of the review are undertaken objectively, and should be conducted by clinicians not directly involved in the care of the deceased wherever possible. Where the clinical expertise required to conduct the review only resides with those who were involved in the care of the patient, the review process should still involve clinicians who were not involved, to provide peer challenge.

The appointed Structured Judgement Reviewer should ensure that wherever possible, the family have been engaged with, and their views are sought prior to commencing the investigation, ensuring that any outstanding queries or concerns they may have are included in the terms of reference for the investigation. The reviewer should ensure that time is allocated to meeting with the family, should they wish to, both prior to commencing the investigation, and also following the production of the report, allowing an opportunity to discuss the report findings and answer any questions they may have.

5. Vulnerable Care Groups

The National Quality Board have identified a number of care groups that have been identified to be at particular risk of sub-optimal care, or areas where learning is required to address a national imbalance in mortality rates compared to other countries.

5.1 Learning Disabilities

The Confidential Inquiry into premature deaths of people with Learning Disabilities (CIPOLD) (2010-2013) raised concerning findings that the deaths of individuals with a Learning Disability were often considered 'expected' or 'inevitable' because of their disability and that they should, but were not always, reported to mandatory review processes, including safeguarding reviews and to the coroner. National work on improving this has commenced via the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQIP) for NHS England. The trust is committed to fully participating in the LeDeR programme and will therefore ensure that all patients meeting these criteria are subjected to Structured Judgement Review.

5.2 Mental Health

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 Structured Judgement Review.

5.3 Children & Young People

NHS England is undertaking a national review of child mortality review processes, for both hospital and community care. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. In the interim, whilst the trust awaits the formation of this programme, all cases of child death within the trust will undergo Structured Judgement Review. The trust will continue to comply with the Child Death Overview Panel (CDOPs) criteria.

5.4 Maternity & Still Births

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) that is currently in development. Its aim is to standardise the reporting of perinatal deaths across all maternity and neonatal units. In the interim, whilst the trust awaits the formation of this programme, all cases of perinatal death within the trust will undergo Structured Judgement Review.

6. Bereaved Families and Carers

6.1 We aim to provide the best care for our patients. However, sometimes things may not go according to plan. We have ensured that bereaved relatives are made aware of the appropriate steps to take if they have outstanding questions or concerns about the care and treatment of relatives.

The trusts bereavement literature has been updated to ensure that families are signposted to the Patient Advice and Liaison Service (PALS) in the first instance. The PALS team can provide confidential advice, information and support for relatives who contact them. They are best placed to resolve local queries and outstanding issues regarding care and treatment of loved ones. If those queries and concerns cannot be resolved they will provide advice and support in the next steps available to the family, including referral for Structured Judgement Review, and / or the formal complaints procedure if appropriate.

Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour and Being Open Policy. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

Where families have raised significant concerns a structured judgement review will be undertaken. This will run concurrently to any other investigations that are required as a result of the concerns raised (e.g. formal complaint, incident investigation, or Serious Incident (SI)).

6.2 Bereavement Support

The trust offers bereavement support via the Patient Affairs Service. They offer a caring and empathetic service at a time of distress and sadness for families and will guide and support relatives through the practical aspects of dealing with bereavement.

6.3 Reviews

If the care of a patient who has died is selected for Structured Judgement Review the trust will:

- Ensure that the views of the family and carers have been considered. The trust will review cases where family and carers have raised a significant concern about the quality of care provision
- Communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

6.4 Investigations

Where the trust feels that a structured judgement review is needed, early contact will be made with bereaved families and carers so that their views help to inform the decision and remit of the review.

Provided the family or carer is willing to be engaged with the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation.

Bereaved families and carers should:

- Be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held
- Be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, on the progress of the investigation
- Have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date
- Be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case
- Have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings
- Be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future
- Have an opportunity to respond to the findings and recommendations outlined in any final report
- Have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided

7. Implementation and Dissemination

7.1 Good practice, learning, actions or concerns identified must be explicit, particularly where this is relevant to other departments. Clinical Governance Structures can be used to share this information locally, address changes in practice and monitor actions taken within specialties. Data from mortality reviews should be triangulated with other information and evidence from other sources, for example, performance dashboard, clinical outcome data and alerts, complaints and audit results.

Figures from Divisional Mortality Reports will be aggregated to provide Trust level data on deaths, particularly focusing on the number of avoidable deaths in the Trust. This data will be reported upwards to the Board via the Executive Committee for Quality (ExQu).

8. References

CQC (2016) Learning, candour and accountability: A review of the wway NHS trusts review and investigate the deaths of patients in England
RCP Mortality Case Record Review Programme
CIPOLD (2010-2013) Confidential Inquiry into People with Learning Disabilities
MoJ (2009) Coroner's and Justice Act.

9. Monitoring Arrangements

Lead	Policy Objective	Method	Frequency	Responsible Committee / Group
Divisional Governance Lead	Number of deaths versus Level 1 Screening in each Division	Weekly report to MD Panel	Weekly	Divisional Director Divisional Q&S Board
Divisional Governance Lead	Number of deaths versus Level 2 Reviews in each Division	Monthly Report to MD Panel	Monthly	Divisional Director Divisional Q&S Board
Mortality Auditor	Number of deaths versus Structured Judgement Reviews for the Trust	Monthly Report to MRG	Monthly	AMD for Safety Mortality Review Group
Mortality Auditor	Number of avoidable deaths reported and number of Structured Judgement Reviews undertaken for the Trust	Monthly Report to MRG	Monthly	AMD for Safety Mortality Review Group
Mortality Auditor	Annual audit of quality of local case reviews	Annual Audit Report	Annual	Medical Director Clinical Audit & Effectiveness Group ExQu

Lead	Policy Objective	Method	Frequency	Responsible Committee / Group
AMD Safety & Effectiveness	Number of avoidable deaths reported and number of Structured Judgement Reviews undertaken for the Trust	Quarterly Report	Annual	ExQu Trust Board

10. Definitions & Abbreviations

10.1 **Definitions**

10.1.1 **Notification of Death Form:** Receipt of this form by the clinical directorate triggers a mortality review.

10.1.2 **Level 1 review:** Contains a series of statements, which the consultant responsible for the patient's care signs as either 'agree' or 'disagree'. Agreement with all statements allows a case to be diverted away from full level 2 mortality reviews.

10.1.3 **Level 2 mortality review:** Full mortality review using a generic template or approved variant. Variations between services may occur but each version contains a small core data set.

10.1.4 **Structured Judgement Review**: is and independent review, conducted by an independent individual, trained in SJR.

10.1.5 **SI:** serious incident requiring investigation.

10.1.6 **Death certification:** The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. The process includes identifying cases for referral to the Coroner

10.1.7 **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. The Serious Incident Policy details the process of investigation, including the different levels of investigations required in specific circumstances

10.1.8 **Duty of Candour:** Health and Social Care Act 2008 Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

10.2 **Abbreviations**

10.2.1 **ICHT:** Imperial College Healthcare NHS Trust

10.2.2 **CQC:** Care Quality Commission

10.2.3 **SJR:** Structured Judgement Review

10.2.4 **PALS**: Patient Advice Liaison Service

10.2.5 **M&M:** Morbidity & Mortality

10.2.6 **MD:** Medical Director

10.2.7 **SI:** Serious Investigation

10.2.8 **MRG:** Mortality Review Group

10.2.9 **ExQu:** Executive Committee for Quality

10.2.10 **CRAB:** Copeland's Risk Adjusted Barometer

10.2.11 **ToR:** Terms of Reference

10.2.12 **MCCD:** Medical Certificate of Cause of Death

10.2.13 **SBAR:** Situation Background Analysis Recommendation

10.2.14 **CIPOLD:** Confidential Inquiry into people with Learning Disabilities

10.2.15 **CDOPs:** Child Death Overview Panel

10.2.16 **HQIP:** Healthcare Quality Improvement Programme

10.2.17 **MBRRACE-UK:** Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

10.2.18 **PMRT:** Perinatal Mortality Review Tool

11. Supporting Information

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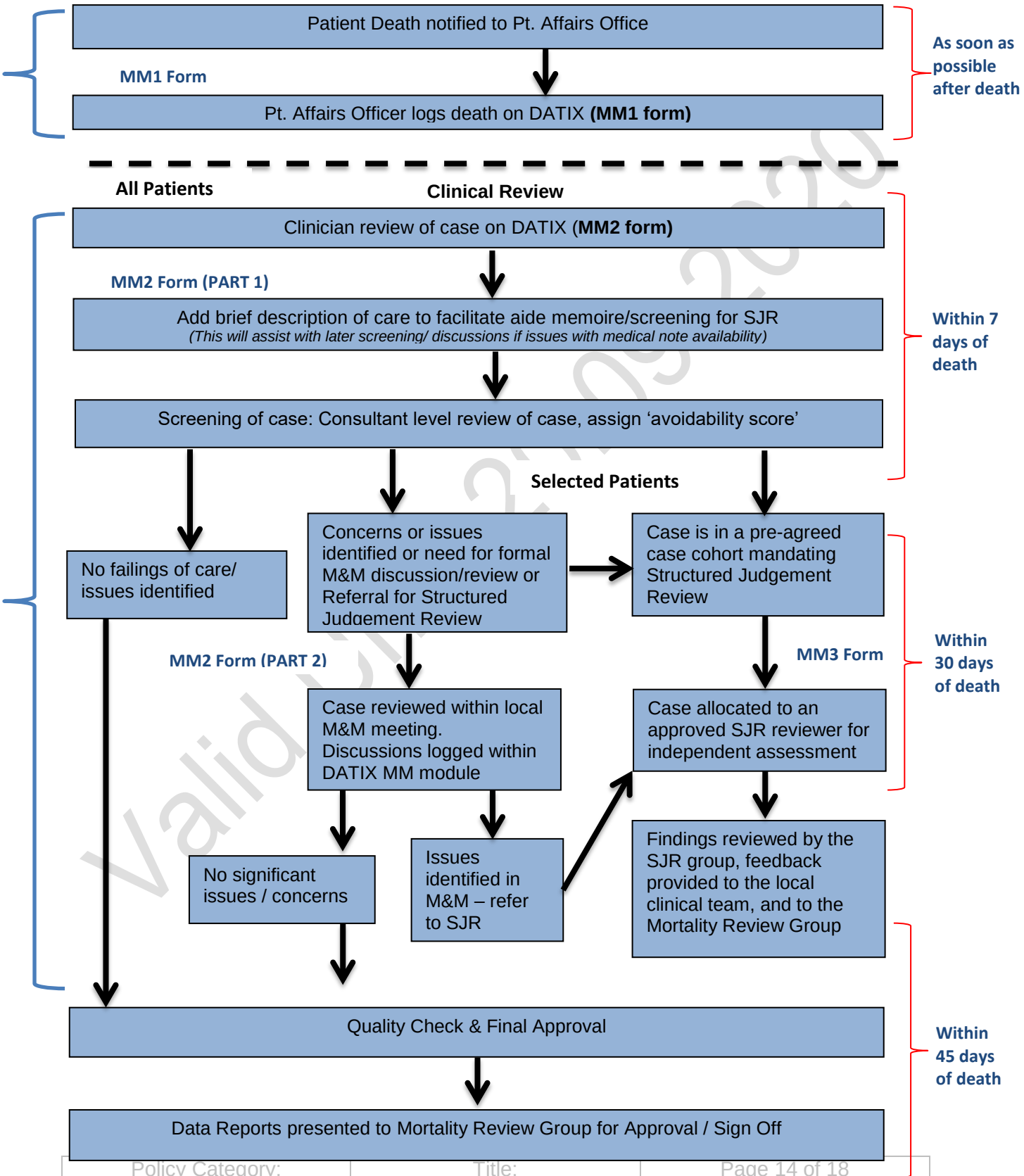
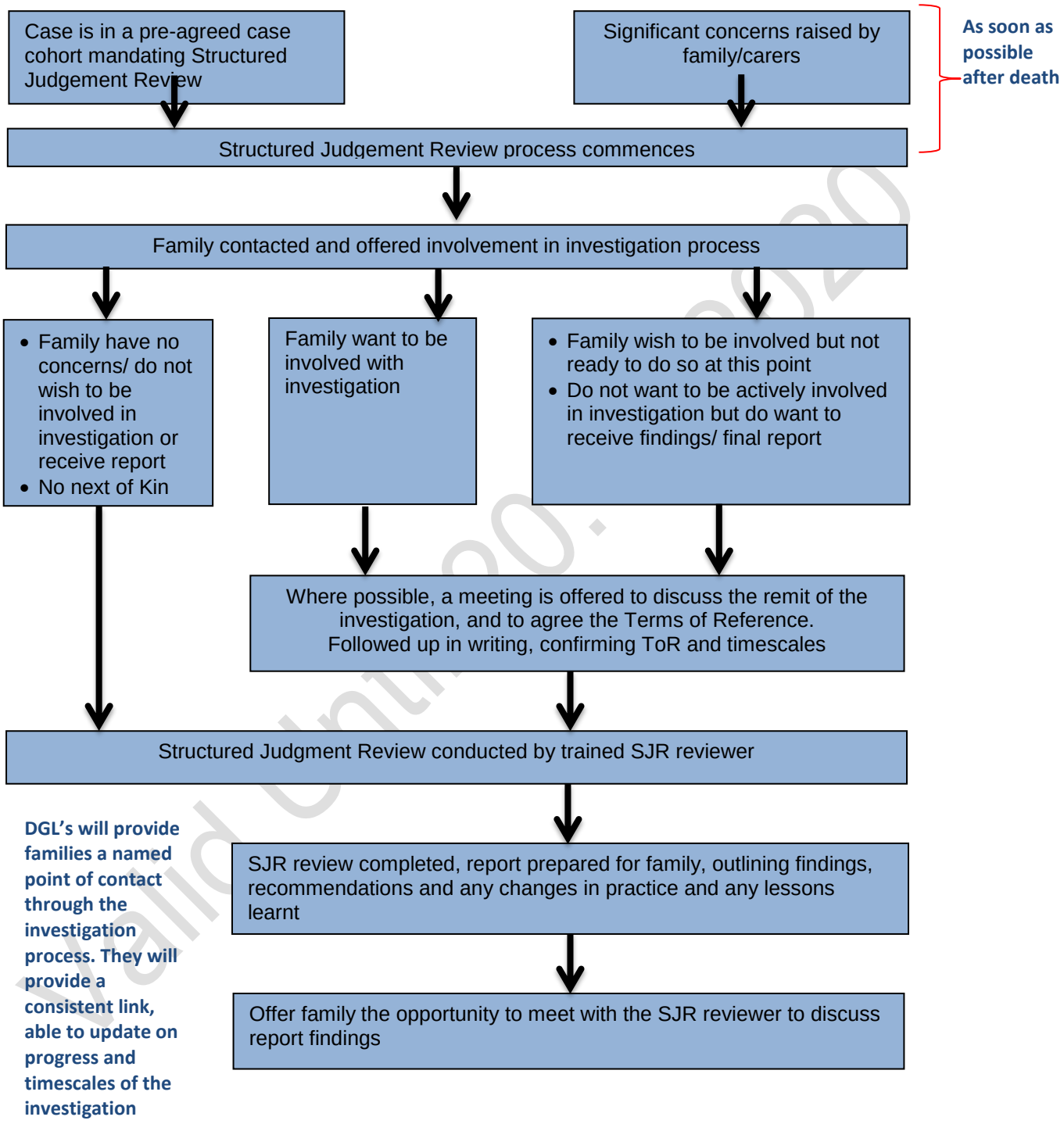
2.0	26.09.2017	Corporate Governance	Final ratified.

Appendix 1

Quick Reference Guide - Mortality Review Process



Quick Reference Guide - Involving Families



Appendix 2

Imperial College Healthcare NHS Trust

Mortality Review Group
Terms of Reference
September 2017

Duties

The Group has been established to provide assurance to the Trust Board that there is a strategic approach to mortality monitoring which ensures that mortality monitoring and learning is in place and in line with national guidance. The group ensures that there is a consistent and effective process for the review of deaths at an organisational level and across all clinical areas.

By benchmarking outcomes and investigation of areas of statistically significant differences the group supports the Trust to examine, monitor and improve the quality of patient care.

The Group's main responsibilities are as follows:-

Strategic

- To provide assurance to the Trust Board that the Trust is meeting all statutory duties for mortality review, and that the Trust's governance processes are effective.
- To provide oversight and approval of trust level mortality data prior to external submission.
- To ensure that there is dissemination of learning from adverse outcomes, and recognition of common themes requiring a systematic approach.
- To share good practice with partner organisations and identify areas of mutual interest or concern. (ICHP / Coroners / Commissioners)
- To engage with the evolving national strategy for Learning from Death.

Local

- To ensure that there is effective governance of mortality within divisions through monitoring of compliance, annual audit and review of the outcomes of Structured Judgement Review
- Support divisions to ensure that appropriate frameworks and structures are in place to monitor mortality.
- Promote and support specialties to fully implement the record of death form, and to conduct proportionate review of all in-hospital deaths.
- Inform and advise the Executive Committee for Quality (ExQu) of any areas of concern and the progress of any necessary investigations arising from Structured Judgement Reviews.

Performance

- To monitor and report mortality metrics in line with national reporting requirements.
- To benchmark mortality at a procedure and diagnostic level and to oversee investigations where outcomes appear to be statistically significantly different to the national average or appropriate peer groups.

Ratification of Procedural Documents

- To ratify procedural documents related to Mortality Review

Reporting

- A summary report for the previous quarter will be included in the Quality Report quarterly (month 3 of each quarter), structured as per external reporting

requirements. This report is presented at ExQu, the Trust Quality Committee and to commissioners at the CQG.

- A quarterly report in line with external reporting requirements will be presented to the Executive Quality Committee, The Board Quality Committee and the Trust Board.
- An annual summary with actions and learning will be included in the Trust Quality Account.

Membership

The core membership of the Mortality Review Group will comprise the following:

- Associate Medical Director for Safety & Effectiveness (Chair)
- Corporate Mortality Auditor
- Head of Compliance and Quality Assurance
- Divisional Clinical Director for Clinical Governance – Medicine & Integrated Care
- Divisional Clinical Director for Clinical Governance – Surgery Cancer & Cardiovascular
- Divisional Clinical Director for Clinical Governance – Women's, Children's & Clinical Support
- Divisional Governance Lead – Medicine & Integrated Care
- Divisional Governance Lead – Surgery Cancer & Cardiovascular
- Divisional Governance Lead – Women's, Children's & Clinical Support
- Two mortality investigators (experts in Structured Judgement Review) from each division

Other Trust officers may be asked to attend the committee as appropriate.

The committee will be chaired by the Associate Medical Director for Safety & Effectiveness, who can request any consultant member of the group to act as Vice-chair.
Each member of the Committee is required to send a deputy in their absence. The importance of attendance by investigators is emphasised and it is mandatory for all Divisions to be represented at the meeting. Attendance at meetings will be monitored.

Administrative support for the committee will be provided by the Safety & Effectiveness Team.

Quorum

A quorum will consist of not less than eight members of the committee, of whom four must be practicing medical clinicians.

Expected Attendance

Members of the Mortality Review Group will be expected to attend each of scheduled meetings throughout the year.

Frequency of Meetings

The Committee will meet monthly during the first year, but this will be reviewed at one year when systems and processes are established.
An extraordinary meeting may be called at the request of the Chairman of the Committee.

Declaration of interests

All committee members must declare any conflict of interests, should they arise, and exclude themselves from the meeting for the duration of that specific item.

Authority

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek and may secure any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Reporting (to Board/High Level Committees)
The Committee will report to the Executive Committee for Quality (ExQu) that in turn reports to the Trust Board, through to the Operational Report.
The Quality Account will incorporate a report from the group.

Secretariat
The Committee shall appoint the a member of the Safety & Effectiveness Team as secretary to prepare agendas, keep minutes and deal with any other matters concerning the administration of the Committee.

Review of Terms of Reference
The Terms of Reference (TOR) will be reviewed six months after the first meeting. Thereafter, the TORs will be reviewed and amended accordingly at regular intervals, as a minimum the Terms of Reference will be reviewed annually.

For Review March 2018